

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14511

CERTIFICATE OF DEATH

14511

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY P.G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
c. LENGTH OF STAY IN lb 4 days		d. STREET ADDRESS 4806 Sheridan Street	
d. NAME OF HOME OR INSTITUTION (If not in hospital, give street address) Prince George General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Adams Middle KEYTON Last ADAMS		4. DATE OF DEATH October 2 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-25-95
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSTRUMENT WORKER		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
11. BIRTHPLACE (County & State, or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JACOB ADAMS		14. MOTHER'S MAIDEN NAME ELIZABETH KEYTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214 039005A	
17. INFORMANT LUCY N. ADAMS		18. ADDRESS SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO 4300 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Sclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARDIAC CIRRHOSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1961 , 19 10-2- , 19 66 that (I) (we) last saw the deceased alive on October 2 1966 and that death occurred at 2:10 PM from causes and on the date stated above.			
22a. SIGNATURE Albert Roth		22b. DATE SIGNED 10-2-66	
22c. PHYSICIAN'S NAME (Type) ALBERT ROTH		22d. ADDRESS RIVERDALE MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5 Oct. 1966	
23c. NAME OF CEMETERY OR CREMATORY Fort LINCOLN CEM		23d. LOCATION (City or Town) (County) (State) BLADENSBURG, MARYLAND	
24. FUNERAL DIRECTOR W.W. Chambers Co Riverdale, Md.		25a. REC'D BY REGISTRAR OCT 5 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14512 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14512

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>47-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlyne</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Maryland Medical Center</u>				d. STREET ADDRESS <u>155 Evergreen Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>Harriet Herma Allen</u>				4. DATE OF DEATH <u>10 10 19 66</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>13 Oct. 1899</u>	
9. AGE (in years last birthday) <u>66</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CURTIS PUB. CO</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>ROBERT G ALLEN</u>			
14. MOTHER'S MAIDEN NAME <u>ANNA M. FISCHER</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>				17. INFORMANT <u>MISS GERTRUDE ALLEN</u> Address <u>SAME AS #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric hemorrhage</u> <u>5410</u> DUE TO <u>Duodenal ulcer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>over 1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u>				22. DATE SIGNED <u>10-11-66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>OCT 14, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loewstweed MEM PARK</u>		23d. LOCATION (City, town or county) (State) <u>CHERRY HILL NEW JERSEY</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers Co., Riverdale, MARYLAND</u>				25a. REC'D BY REGISTRAR <u>DATE OCT 14 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14513		14513									
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6811- RIGGS RD.</u>				d. STREET ADDRESS <u>HYATTSVILLE MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL MANOR</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>REBECCA</u> Last <u>AULEN</u>						4. DATE OF DEATH Month <u>Oct</u> Day <u>25</u> Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 3, 1879</u>		9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>NORFOLK VA.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>GEORGE HOGWOOD</u>						14. MOTHER'S MAIDEN NAME <u>SARAH</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>N</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS GLADYS LA SCOLA</u>		Address <u>6811-RIGGS RD. HYATTSVILLE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 4200 DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized osteoporosis - marked kyphosis</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1959</u> , to <u>Oct 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 24, 1966</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Darryl N. Carlton</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Oct 26, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>HARRY N. CARLTON</u>						22d. ADDRESS <u>909 Pershing Dr. Silver Spring Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Oct 28-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		23d. LOCATION (City, town or county) (State) <u>ARLINGTON VA.</u>			
24. FUNERAL DIRECTOR <u>Charles Walters, 254 Carroll Pl NW-102</u>						25a. REC'D BY REGISTRAR DATE <u>OCT 31 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14514

CERTIFICATE OF DEATH

14514

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN lb 24 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FALLS CHURCH
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		d. STREET ADDRESS 1002 KENNEDY STREET	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last FRANCES R. ASHLEY		4. DATE OF DEATH Month Day Year OCTOBER 22 1966	
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 NOV 1888
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) WISCONSIN		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME LOUIS E. FREDERICKSON		14. MOTHER'S MAIDEN NAME HANSEN, Hansen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 388-14-8438	
17. INFORMANT John F. Rohloff, 1002 KENNEDY ST., FALLS CHURCH, VA.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarction 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic congestive heart failure of unknown cause			INTERVAL BETWEEN ONSET AND DEATH 12 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6 Mar, 1966 to 22 Oct, 1966 , that (I) (we) last saw the deceased alive on 22 Oct 1966 , and that death occurred at 0940 A.M. from causes and on the date stated above.			
22a. SIGNATURE Charles D. Phelps		22b. DATE SIGNED 22 Oct 66	
22c. PHYSICIAN'S NAME (Type) CHARLES D. PHELPS		22d. ADDRESS 914 PALMER RD., OXON HILL, MD.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/26/66	23c. NAME OF CEMETERY OR CREMATORY Elmwood	23d. LOCATION (City or Town) (County) (State) Antigo, Wisc.
24. FUNERAL DIRECTOR W.W. Chambers & Inc. 1400 Chapin St. N.W. Wash, D.C.		25a. REC'D BY REGISTRAR OCT 26 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14515 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14515

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
c. LENGTH OF STAY IN 1d DOA		d. STREET ADDRESS 3232 Chillum Road, Apt. 201	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chamber's Funeral Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Bertha Louise Baker		4. DATE OF DEATH Month Day Year 10 17 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9 May 1907
9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME KARL G. XANDER		14. MOTHER'S MAIDEN NAME ANNA M. HARR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT CLARA C. FRAZIER		Address 3343 BUCHANAN ST. MT. RAINIER, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gum shot wound of head 976 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self at home.	
20c. TIME OF INJURY Month, Day, Year about 1:00am p.m. 10-17 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bedroom of home		20f. (City or town) (County) (State) same as #2	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 10-18-66	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF Oct 18, 1966	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CREMATORY	23d. LOCATION (City, town or county) (State) BLADENSBURG, MARYLAND
24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.		25a. REC'D BY REGISTRAR OCT 19 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE
HEALTH DEPT.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G382 11/15/66 mh

14516

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14516

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 55 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 5519 Nicholson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mayme Middle Bakersmith Last 4. DATE OF DEATH Month 10 Day 31 Year 19 66							
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 Oct. 1895	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Trammell				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577 48 7378		17. INFORMANT Harry A Miller		Address Seat Pleasant, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary emboli 9040 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) From Phlebo thrombosis DUE TO From sub trochanteric fracture of right femur (c) INTERVAL BETWEEN ONSET AND DEATH 55 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:00amp.m. 9-6- 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) same as #2	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		M.D. John Kehoe, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 11-1-66	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 4, 1966		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 7 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

14514

14514

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14517
14517

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HYATTSVILLE c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HYATTSVILLE NURSING HOME				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) W Hyattsville d. STREET ADDRESS 3908 Commander Dr College Park e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last DOROTHEA A. BALDERSON				4. DATE OF DEATH Month Day Year 10-13 1966			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-10-1892	
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James J. Holzer				14. MOTHER'S MAIDEN NAME IDA Alvina Holzer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-10-872		17. INFORMANT Ernest Goodwin Address 3205 Rittenhouse St W Wash, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X OUE TO (b) General atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 15, 1966 , to Oct 13, 1966 , that (I) (we) last saw the deceased alive on Oct 6, 1966 , and that death occurred at 10 A.M. from the causes and on the date stated above.							
22a. SIGNATURE LW Malin						22b. DATE SIGNED 10-13-66	
22c. PHYSICIAN'S NAME (Type) LW Malin M.D.						22d. ADDRESS Burkdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-17-66		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		23d. LOCATION (City, town or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR Joseph Harker's Sons				25a. REC'D BY REGISTRAR Wash, D.C.		25b. REGISTRAR'S SIGNATURE Charles Judge	

1951

14511

HYPERVOLUME NURSING HOME
34 days
MARTIN
FATHERS

BRIDGEMAN
10-12
X

VI
10-12

VI
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VI
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VI
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14518

CERTIFICATE OF DEATH

14518

Items 1c, 2, 10b, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Hyattsville Res'g Home		d. STREET ADDRESS 7431 Baltimore Ave. 6800 Riggs Rd Hyattsville Md.	
3. NAME OF DECEASED (Type or print) OSCAR LEVI Bancroft		4. DATE OF DEATH 10 28 19 66	
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/5/1881	
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government Clerk		11b. KIND OF BUSINESS OR INDUSTRY Federal Government	
12. BIRTHPLACE (County & State, or foreign country) Spink Co. South Dakota		13. CITIZEN OF WHAT COUNTRY? yes usa	
14. FATHER'S NAME LOREY JEROME		15. MOTHER'S MAIDEN NAME Rozelen Jane Morse	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		17. SOCIAL SECURITY NO. 58-32-2313	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA; RESPIRATORY ARREST 331X DUE TO (b) CEREBRAL VASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) SEVERE GENERALIZED ATHEROSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 48 HRS. 13 DAYS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/30, 1966, to 10/28, 1966, that (I) (we) last saw the deceased alive on 10/27, 1966, and that death occurred at 12:02 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Harold W. Draper		22b. DATE SIGNED 10/28/66	
22c. PHYSICIAN'S NAME (Type) HAROLD W. DRAPER M.D.		22d. ADDRESS 911 SILVER SPRING AVE; SILVER SPRING	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 31, 1966	
23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION (City, town or county) (State) Adelphi Pr Geo Md	
24. FUNERAL DIRECTOR Arthur Waters Washington, D.C.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
DATE OCT 31 1966			

14512

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Oct 1 1960

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14519

14519

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY in 1b <u>DOA</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mingo Junction</u> 72-3			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General</u>				d. STREET ADDRESS <u>2407 Commercial Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>GILBERT</u> Last <u>BARCUS</u>				4. DATE OF DEATH <u>Oct 2</u> 19 <u>66</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 19 1916</u>		9. AGE (in years last birthday) <u>49</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Millrite</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Mingo Junction Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES EDGAR BARCUS</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA MAYO</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Robert Barcus</u> Address <u>Mobile Home</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema - 72 minutes</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary arterio sclerosis 2 years</u> DUE TO (c) <u>myocardial fibrosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Daglor O Watkins</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bladenburg Md</u>			
EXAMINER'S NAME (Type) <u>DAYON O WATKINS</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <u>10-3-66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/7/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Alexandria Cem.</u>		23d. LOCATION (City, town or county) (State) <u>New Alexandria, Ohio</u>	
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>				25a. REC'D BY REGISTRAR <u>OCT 5 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

14513

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove it from the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 5-63

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																
1. PLACE OF DEATH e. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8861 River View Road						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill d. STREET ADDRESS 8861 River View Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>										
3. NAME OF DECEASED (Type or print) Henry A. Bartholomew			4. DATE OF DEATH October 12 1966			5. SEX male			6. COLOR OR RACE white							
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 12/8/82			9. AGE (In years last birthday) 83 yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>			IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.														
Months	Days	Hours	Min.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President of Continental Life Insurance N.C.						10b. KIND OF BUSINESS OR INDUSTRY										
11. BIRTHPLACE (County & State, or foreign country) U.S.A.						12. CITIZEN OF WHAT COUNTRY?										
13. FATHER'S NAME Augustus Bartholomew Co.						14. MOTHER'S MAIDEN NAME Lucy Mitchell										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO. 577-10-5779 17. INFORMANT Vernon Cox 8861 River View Rd. Oxon Hill, Md.										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure, pulmonary edema 2900 DUE TO Pernicious Anemia. pneumonia. 1945 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)																
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1935 , 19 to 10-12-66 , that (I) (we) last saw the deceased alive on 10-12-66 , 19 , and that death occurred at 1450 AM from the causes and on the date stated above.																
22a. SIGNATURE Frederick A. Reuter M.D.						22b. DATE SIGNED 1966										
22c. PHYSICIAN'S NAME (Type) 2520 L ST NW						22d. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF 10/14/66			23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			23d. LOCATION (City, town or county) (State) Prince Georges County, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company 2901 14th St. N.W. Washington, D.C.						25a. REC'D BY REGISTRAR DATE OCT 17 1966 25b. REGISTRAR'S SIGNATURE Charles Judge										

MEDICAL CERTIFICATION

14520

14520

CERTIFICATE OF DEATH

State of New York
County of New York
City of New York
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 15th day of December, 1940, at New York City, New York, I attended the body of
Name of Deceased
and found that she had died of
Cause of Death
at the residence of the deceased, 1234 Fifth Avenue, New York City, New York.

Witness my hand and the seal of my office this 15th day of December, 1940.
Signature of Physician
M.D.
New York City, New York

Subscribed and sworn to before me this 15th day of December, 1940.
Notary Public for the State of New York
My Commission Expires on the 15th day of December, 1941.

Attest:
Notary Public for the State of New York
My Commission Expires on the 15th day of December, 1941.

Filed for record this 15th day of December, 1940.
County Clerk of New York
New York City, New York

Recorded this 15th day of December, 1940.
County Clerk of New York
New York City, New York

14520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14521

CERTIFICATE OF DEATH

14521

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Naylor d. STREET ADDRESS RFD Bx. 3569 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Oden Middle Lee Last Beall		4. DATE OF DEATH Month October Day 13 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/27/80
9. AGE (In years last birthday) 86		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Tobacco)		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clinton Beall		14. MOTHER'S MAIDEN NAME Mary Stockett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-46-7025	
17. INFORMANT J. Francis Beall-Same as Item #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Interoskeletal CVR Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 3 days 2 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 19 54 , to 13 Oct , 19 66 , that (I) (we) last saw the deceased alive on 13 Oct , 19 66 , and that death occurred at 8:40 PM , from causes and on the date stated above.			
22a. SIGNATURE Robert B. G. Sasscer		22b. DATE SIGNED 10-14-66	
22c. PHYSICIAN'S NAME (Type) Robert B. G. Sasscer		22d. ADDRESS RFD Bx. 2150, Upper Marlboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/17/66	
23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		23d. LOCATION (City or Town) (County) (State) Upper Marlboro Md.	
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR OCT 25 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

14551

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14522 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14522									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) b. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital					d. STREET ADDRESS 1400 Jefferson Street				
3. NAME OF DECEASED (Type or print) John Lemuel Beaton			First Middle Last		4. DATE OF DEATH 10 12 19 66		Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20 April 1914		9. AGE (In years last birthday) 52 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired -G.A.O.			10b. KIND OF BUSINESS OR INDUSTRY U.S.Govt.		11. BIRTHPLACE (State or foreign country) North Dakota			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John P. Beaton					14. MOTHER'S MAIDEN NAME Malloy F. Talley				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 220-40-6191		17. INFORMANT Mrs. Edna L. Beaton (above address)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] (Wife) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, Bilateral 3220 DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Acute Intoxication Ethyl Alcohol (0.32%) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Kehoe, M.D.					22. DATE SIGNED 10-13-66				
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.					Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/15/66		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Wash., D.C.		
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. Maryland					25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge				
DATE OCT 17 1966									

1952

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14523

CERTIFICATE OF DEATH

14523

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 70 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood, 16.1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 4001 38th St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Julia Elizabeth Beckdahl		4. DATE OF DEATH Month Day Year October 29, 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/22/86
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Ralph B. Wyrick		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. none	
17. INFORMANT Carl F. Beckdahl		Address 4001 38th St. Brentwood, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Bilateral Bronchopneumonia DUE TO (b) ASHD DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 1963, to October 29, 1966, that (1) (we) last saw the deceased alive on October 29, 1966, and that death occurred at 10:45M, from causes and on the date stated above.			
22a. SIGNATURE Benjamin S. Miller		22b. DATE SIGNED 10.30.66	
22c. PHYSICIAN'S NAME (Type) BENJAMIN S. MILLER		22d. ADDRESS Prince George County Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-2-66	
23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City or Town) (County) (State) Suitland, Md.	
24. FUNERAL DIRECTOR W.W. Chambers		25a. REC'D BY REGISTRAR NOV 2 1966	
ADDRESS Co. Riverdale, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

65244

10252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

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2

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14524					14524				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
COUNTY Prince George's MARYLAND					a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Cheverly			2 days		Glendale				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Prince George's General Hospital					Brooklyn Road			16.1	
3. NAME OF DECEASED (Type or print)			First Middle Last		4. DATE OF DEATH		Month Day Year		
Charles			Bell		October		27 19 66		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH		9. AGE (In years lost birthday) Yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male	Negro		Apr 21, 1931		35	Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
					Lanham Md			U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Webster Bell					Mildred Prayton				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address	
Yes					Raymond Bell			Same as 2D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a)									
451X DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO									
Directing Aneurysm, Aorta with									
(c) DUE TO									
intra pericardial tear									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from Oct. 25, 1966, to Oct. 27, 1966, that (X) (we) last saw the deceased alive on October 27 19 66, and that death occurred at 11:00 M, from causes and on the date stated above.									
22a. SIGNATURE					ATTENDING PHYS. MED. am DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
Roger B. Ingham							10-28-66		
22c. PHYSICIAN'S NAME (Type) Roger B. Ingham, M.D.					22d. ADDRESS 5701 85th Ave. Carrollton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
			11-1-66		Arlington Nat		Arlington VA		
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
H.S. Washington & Sons					4925 Penne Ave		NOV 3 1966		Charles Judge

1321

2525

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
14525					14525					
1										
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RIVERDALE c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) LELAND MEM HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Maryland RIVERDALE 16.1 d. STREET ADDRESS 5903 Harrison AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) OSCAR W. BENKERT.					4. DATE OF DEATH Month Oct Day 31 Year 1966					
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 JULY 1891		9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER + DECORATOR					10b. KIND OF BUSINESS OR INDUSTRY DECORATING		11. BIRTHPLACE (County & State, or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHANN BENKERT					14. MOTHER'S MAIDEN NAME UNKNOWN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577 037978A		17. INFORMANT MISS EDITH A. BENKERT		Address SAME AS #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Arteriosclerotic Heart Disease (b) Myocardial Infarction (c) Arteriosclerotic Heart Disease										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
MEDICAL CERTIFICATION										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1964 to 10-31, 1966 , that (I) (we) last saw the deceased alive on 10-16, 1966 , and that death occurred at 3 P.M. from the causes and on the date stated above.										
22a. SIGNATURE Donald C. Edgren					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-1-1966	
22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN					22d. ADDRESS HYATTSVILLE, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4 NOV 1966		23c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON MEM PR		23d. LOCATION (City, town or county) (State) HYATTSVILLE, MARYLAND				
24. FUNERAL DIRECTOR W. W. Chambers Co., Riverdale, Md.					25a. REC'D BY REGISTRAR DATE NOV 3 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

2321

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14526

14526

1. PLACE OF DEATH o. COUNTY <u>Prince Georges.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u>		d. STREET ADDRESS <u>8318 14th Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>-</u> Last <u>Berlin</u>		4. DATE OF DEATH Month <u>10</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 15, 1883</u>
9. AGE (In years ? last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR (RET.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MOSHE BERLIN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>064-01-7380</u>	
17. INFORMANT <u>ROSE BERLIN - SAME AS 2.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>12 bronchopneumonia left lower lobe</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(d) <u>generalized arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/19</u> , 19 <u>66</u> to <u>10/2</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10/1</u> , 19 <u>66</u> , and that death occurred at <u>11-A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Peter Duus</u>		22b. DATE SIGNED <u>10-2-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>PETER DUUS</u>		22d. ADDRESS <u>6124 CENTRAL AVE CAP HTS. MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/3/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BETH ISRAEL Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>WOODBRIDGE, N.J.</u>	
24. FUNERAL DIRECTOR <u>Soldberg Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 5 1966</u>	
ADDRESS <u>4217-9th St. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

14234

UNIT 10-10-10

14234

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14527

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14527

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 2736 St. Paul St.	
3. NAME OF DECEASED (Type or print) Lewis A		4. DATE OF DEATH 10 30 19 66	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Nov 1939
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY College	
13. FATHER'S NAME Lewis A. Bicking Sr.		14. MOTHER'S MAIDEN NAME Dorothy Kauffroth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Dorothy Botdorf.		Address 38 Ridge Ave. Phoenixville, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain 815+ DUE TO Trauma-auto accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO			INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of motorcycle hit from behind by auto	
20c. TIME OF INJURY Hour a.m. 2:25 p.m. 10-3-66	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) University Blvd.	20f. (City or town) (County) (State) P.G. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 10-30-66	
EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-2-66	23c. NAME OF CEMETERY OR CREMATORY Morris Cemetery	23d. LOCATION (City, town or county) (State) Phoenixville, Pa.
24. FUNERAL DIRECTOR W. W. Chambers Co. Inc. Riverdale, Md.		25a. REC'D BY REGISTRAR DATE NOV 2 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 8, 9 Film G382 11/4/66 mh

14528

CERTIFICATE OF DEATH

14528

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New York b. COUNTY 69-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bronx d. STREET ADDRESS 870 Rosendale Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nora Middle F. Last Bijesse		4. DATE OF DEATH Month October Day 16 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1895 June 1, 1892
9. AGE (In years last birthday) 71 72 yrs.		10. IF UNDER 1 YEAR Months 71 Days 72 Hours 72 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jermiah Mullins		14. MOTHER'S MAIDEN NAME Hannah Duggan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 063-20-5945	
17. INFORMANT Ernest F. Bijesse (Same as # 2)		Address Ernest F. Bijesse (Same as # 2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 210 X DUE TO Generalized Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cylindroma of buccal mucosa DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from October 11, 19 66 , to October 16, 19 66 that he (we) last saw the deceased alive on October 16, 19 66 , and that death occurred at 9:35 PM , from causes on and on the date stated above.			
22a. SIGNATURE M. P. Diaz-Giorle		22b. DATE SIGNED 10-17-66	
22c. PHYSICIAN'S NAME (Type) M. P. Diaz-Giorle, M.D.		22d. ADDRESS Prince George's Genl. Hosp., Cheverly, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/20/66	
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City or Town) (County) (State) New York, New York	
24. FUNERAL DIRECTOR F. Gasch's Sons 4739 Balt. Ave., Hyattsville Md.		25a. REC'D BY REGISTRAR OCT 19 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Md. b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN ID DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS Glen Eagle-Bozman	
3. NAME OF DECEASED (Type or print) First Middle Last Randolph Garland Bishop		4. DATE OF DEATH Month 10 Day 15 Year 19 66	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 21, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Westley Graham Bishop		14. MOTHER'S MAIDEN NAME Annie Frances Loane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W W I		16. SOCIAL SECURITY NO. 579-44-4070	
17. INFORMANT Address Bethesda, Md. Randolph B. Bishop, 9408 Seddon Dr.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D., Riverdale		22. DATE SIGNED 10-15-66	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/18/66	
23c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Washington, D.C.		25a. REC'D BY REGISTRAR OCT 19 1966	
		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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[Handwritten signature]

Received by Special Agent in Charge, U.S. Department of Justice, Washington, D.C., on 10/10/50

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14530

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Churchley		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cedar Heights 16.1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General		d. STREET ADDRESS 1129 - 65 Ave	
3. NAME OF DECEASED (Type or print) First Middle Last WARREN (NMN) BLACK Jr		4. DATE OF DEATH Month 10 - 5 Year 1966	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6 1928 37 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Greenville S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Warren Black		14. MOTHER'S MAIDEN NAME Ella Ann Harris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes US Army		16. SOCIAL SECURITY NO. 6408-1	
17. INFORMANT Atis Black Cedar Heights Md		Address 1129 - 65 Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage + Shock 2 hours 981X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laceration of Right iliacover " (c) Gun shot wound abdomen "			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gunshot wound Shotgun	
20c. TIME OF INJURY Month, Day, Year 100 a.m. 10-5-66 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Cedar Heights Md (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dayton O Watkins		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 10-6-66	
EXAMINER'S NAME (Type) DAYTON O WATKINS		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 5318 Annapolis	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Blodinsky Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-10-66	
23c. NAME OF CEMETERY OR CREMATORY Harmony		23d. LOCATION (City, town or county) Lanham, Md. (State)	
24. FUNERAL DIRECTOR Rollins Funeral Home 4339 Hunt Pl., N.E. 24 - 24		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge	
		DATE OCT 11 1966	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**FOR STATE
HEALTH DEPT.**

14531

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14531

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN lb <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colmar Manor</u> d. STREET ADDRESS <u>3616 39th. Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bernard B. Blandford</u>			4. DATE OF DEATH Month Day Year <u>10 31 1966</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 March 1909</u>		9. AGE (In years lost birthday) yrs. <u>57</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>			
13. FATHER'S NAME <u>Thomas S. Blandford</u>			14. MOTHER'S MAIDEN NAME <u>Emma T. Carroll</u> Md				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hillcrest Hgts Edna Blandford 2415 Colebrooke Drive</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemothorax, right side</u> DUE TO <u>and hemoperitoneum</u> (b) <u>From lacerations of right lower lung and liver</u> DUE TO <u>From multiple gun shot wounds</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot by assailants</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>1:00am 10-31- 19 66</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Prince George County, Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my apinian death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D. EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>			22. DATE SIGNED <u>10-31-66</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11-3-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>			
24. FUNERAL DIRECTOR <u>Spencer Mattingly</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
23d. LOCATION (City or Town) (County) (State) <u>Piscataway, Md</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

14532

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14532

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forest Heights				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 332 Cree Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas J. Blohm				4. DATE OF DEATH Month Day Year October 7 19 66			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-8-13	
9. AGE (In years last birthday) 33 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Property Manager--Weaver Bros.				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME George Blohm				14. MOTHER'S MAIDEN NAME Mary Flanigan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 578-10-9167			
17. INFORMANT Mildred L. Blohm				Address Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of abdomen 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with shotgun					
20c. TIME OF INJURY Month, Day, Year 12 Noon a.m. 10-7-66 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Same as in 2	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.				22. DATE SIGNED 10-8-66			
EXAMINER'S NAME (Type) John Kehoe, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Riverdale, Md. Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 10-1966		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Simmons Bros.				25a. REC'D BY REGISTRAR DATE OCT 11 1966			
ADDRESS 1601 Good Hope Rd SE Wash DC				25b. REGISTRAR'S SIGNATURE J Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14533

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14533

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 223 Maryland Avenue			
3. NAME OF DECEASED (Type or print) First Arthur Middle Lewis Last Brightley				4. DATE OF DEATH Month 10 Day 25 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 25 March 1904		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Gov't.		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jack Brightley				14. MOTHER'S MAIDEN NAME Rose Heck			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Margaret L. Brightley (above address)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Hypertensive arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH over 2 yrs.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D. EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				22. DATE SIGNED 10-26-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/28/66		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				25a. REC'D BY REGISTRAR OCT 31 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

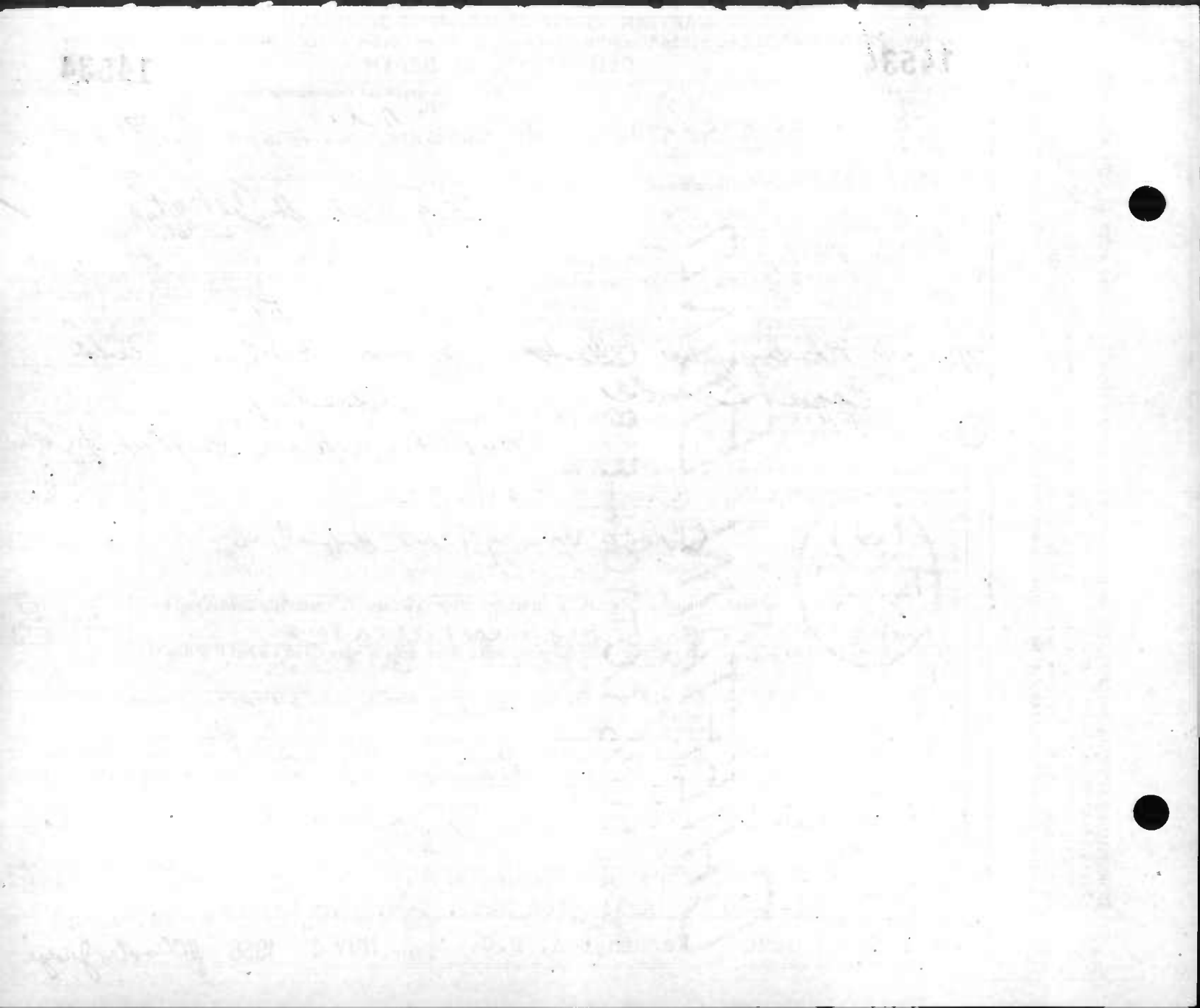
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14534 CERTIFICATE OF DEATH 14534

1. PLACE OF DEATH a. COUNTY <u>Prince George County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>P. G.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>16.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hyattsville Maryland</u>				d. STREET ADDRESS <u>3529 Duke St. College Park</u>			
3. NAME OF DECEASED (Type or print) <u>Philip</u> First <u>Samuel</u> Middle <u>Brooke</u> Last				4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/1/07</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>31</u> Days <u>19</u> Hours <u>66</u> Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Naval Photographer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Govt</u>			
13. FATHER'S NAME <u>Eppa Brooke</u>				14. MOTHER'S MAIDEN NAME <u>Steeley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr Rbt. Caskion</u> Address <u>3529 Duke St. College Park</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> 609X DUE TO <u>Chronic Urinary Tract Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Urinary Tract Infection</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cerebrovascular Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 hr</u> <u>6 mo</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>31 Oct.</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>31 Oct.</u> , 19 <u>66</u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm d. W. Wm</u>				22b. DATE SIGNED <u>31 Oct. 1966</u>		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-4-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>				25a. REC'D BY REGISTRAR <u>NOV 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14535

14535

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pro George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md		c. LENGTH OF STAY IN 1b 56 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.		d. STREET ADDRESS Mowatt Lane	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mowatt Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arthur Middle Buddington Last Buddington		4. DATE OF DEATH Month Oct Day 19 Year 19 66	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1886
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY self	
11. BIRTHPLACE (County & State, or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Buddington		14. MOTHER'S MAIDEN NAME Dorothy A. Comstock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218 34 5563	
17. INFORMANT John J. Gude		Address Silver Springs, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Cardiac Failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from October 19, 1966 to October 19, 1966 , that (I) (we) last saw the deceased alive on October 19, 1966 , and that death occurred at 7:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE Donald C. Edgren		22b. DATE SIGNED Oct 19, 1966	
22c. PHYSICIAN'S NAME (Type) Donald C. Edgren		22d. ADDRESS Prince Georges Plaza Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 21, 1966	23c. NAME OF CEMETERY OR CREMATORY St John's Cemetery	23d. LOCATION (City or Town) (County) (State) Beltsville Pro Georges Md
24. FUNERAL DIRECTOR P. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE OCT 24 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2624

2664

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 16. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14536 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14536

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u> <u>16.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4308 Kaywood Drive</u>				e. STREET ADDRESS <u>4308 Kaywood Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Eunice TWOMBLY Burr</u>				4. DATE OF DEATH <u>10 10 19 66</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3-23-1909</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>GEORGE P. TWOMBLY</u>			
14. MOTHER'S MAIDEN NAME <u>BESSIE BALL</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WW II</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>MRS LOUISE E. PRINTZ</u> Address <u>779 S. QUINCY ST ARLINGTON, VA</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 4200 DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u>				22. DATE SIGNED <u>10-10-66</u>			
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT 12 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT. CEM</u>		23d. LOCATION (City, town or county) (State) <u>ARLINGTON, VA</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers Co</u>				25a. RECORD BY REGISTRAR <u>10-13-66</u> REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
ADDRESS <u>RIVERDALE M.D.</u>				DATE			

14530

NEEDLE EXAMINER'S CERTIFICATE OF DEATH

14530

[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and a copy event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14537

CERTIFICATE OF DEATH

14537

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 6 mos., 12 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle E. Last Butler		4. DATE OF DEATH Month 10 Day 6 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/8/1913
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Delivery-man		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jesse Butler		14. MOTHER'S MAIDEN NAME Mattie Lewis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-16-0556	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis 0021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (s) (this hospital) attended the deceased from 3/25/ , 19 66 , to 10/6/ , 19 66 that (s) (we) last saw the deceased alive on 10/6/ , 19 66 , and that death occurred at 6:40 AM , from causes on and on the date stated above.			
22a. SIGNATURE <i>Moe Weiss</i>		22b. DATE SIGNED 10/6/66	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 10/2/66	
23c. NAME OF CEMETERY OR CREMATORY ANATOMICAL BOARD		23d. LOCATION (City or town) (County) (State) Washington, D. C.	
24. FUNERAL DIRECTOR <i>Carl F. Ruppert</i>		25a. REC'D BY REGISTRAR OCT 20 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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10/20/2011 10:00 AM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <div>1</div> <div>14538</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> <div> <div>14538</div> </div> </div>																				
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 65 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY District of Columbia 27 Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, D. C. d. STREET ADDRESS 1415 52nd Ave., N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Joseph William Butler			4. DATE OF DEATH October 1 19 66		5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH 4/4/23			9. AGE (In years last birthday) 43 yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (County & State, or foreign country) Waldorf, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
IF UNDER 1 YEAR		IF UNDER 24 HRS.																		
Months	Days	Hours	Min.																	
13. FATHER'S NAME Harry Clay Butler (D)					14. MOTHER'S MAIDEN NAME Gertrude Savoy (D)															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 219-12-3519		17. INFORMANT Helen T. Butler, Wife		Address 1415-52nd. Ave., Beaver Heights, Md.													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fungating carcinoma middle third of esophagus (b) involving trachea & later lymph nodes (c) Bronchopneumonia (terminal) 150X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from July 28 , 19 66 , to Oct. 1 , 19 66 , that (I) (we) last saw the deceased alive on Oct. 1 , 19 66 , and that death occurred at 9:15M , from the causes and on the date stated above.																				
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) James W. Harding, M. D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 10-1-66												
22d. ADDRESS 7601 Riverdale Rd., Lanham, Md.																				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Oct. 5, 1966		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Washington, D.C.													
24. FUNERAL DIRECTOR Rollins Funeral Home, Inc.					ADDRESS 4339 Hunt Pl. N.E.		25a. REC'D BY REGISTRAR OCT 5 1966		25b. REGISTRAR'S SIGNATURE 											

1-1538

1-1538

Director of Customs

Prince George's

Washington, D. C.

30 days

Provision

1015 2nd Ave., N.E.

Prince George's General Hospital

William T. Butler

James

X

Colored

Male

Government

Married

Gettysburg, Pa.

1015 2nd Ave., N.E.

1-15-38

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VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14539

Item 8 Film G301 10/13/66 mh

CERTIFICATE OF DEATH

14540

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 6007 40th Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last Ethel M. Calhoun				4. DATE OF DEATH Month Day Year Oct 7 1966			
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1898	9. AGE (In years last birthday) 68 yrs.	10. UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (County & State, or foreign country) Ches		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Richards				14. MOTHER'S MAIDEN NAME Ann Richards			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Edward B. Calhoun Address 5900 Knalbrook Hyattsville, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) mammary carcinoma DUE TO (c) 4 years						INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (was hospital) attended the deceased from 10-2 , 19 66 , to 10-8 , 19 66 , that (I) (was) last saw the deceased alive on 10-7 , 19 66 and that death occurred at 11:15 P. from causes and on the date stated above.							
22a. SIGNATURE Harry N. Carlton				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Oct 8, 1966	
22c. PHYSICIAN'S NAME (Type) HARRY N. CARLTON				22d. ADDRESS 909 Potomac Dr. Silver Spring, Md			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 11, 1966		23c. NAME OF CEMETERY OR CREMATORY Mount Union Cemetery		23d. LOCATION (City or Town) (County) (State) Mencktown, Penna	
24. FUNERAL DIRECTOR Arthur Walters ADDRESS 254 Carroll St. Takoma Park, Md				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
				DATE OCT 11 1966			

MEDICAL CERTIFICATION

14540

CERTIFICATE OF DEATH

1453

Prince George's General Hospital	
Georgetown, Guyana	
Patient's Name: _____	
Age: _____ Sex: _____	
Date of Birth: _____	
Date of Death: _____	
Cause of Death: _____	
Physician's Signature: _____	
Hospital Seal: _____	
Registrar's Signature: _____	
Date of Registration: _____	

NOT RECORDED OR INDEXED
IN THE DEPARTMENT OF
HEALTH AND SOCIAL SERVICES
GUYANA
1970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14540

CERTIFICATE OF DEATH

14541

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 1 1/2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Willis Middle H. Last Canada Sr.		4. DATE OF DEATH Month October Day 8 Year 1966	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/27/08
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Hanger		10b. KIND OF BUSINESS OR INDUSTRY Wyoming	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Henry Canada		14. MOTHER'S MAIDEN NAME Sally Harrold	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. Marines 1924-25 579-09-5596	
17. INFORMANT decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic cor pulmonale DUE TO 0021 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) far advanced pulmonary tuberculosis (c) 2 yrs., 7 mos.		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis; chronic pyelonephritis.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from 5/14/65 to 10/8/66 , that (A) (we) last saw the deceased alive on 10/8/66 , and that death occurred at 7:00 PM , from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 10/8/66	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/13/66	23c. NAME OF CEMETERY OR CREMATORY CEASAR HILL	23d. LOCATION (City or Town) (County) (State) SOUTHLAND MD.
24. FUNERAL DIRECTOR LEE FUNERAL HOME		ADDRESS 3004 ST. N.E.	
25a. REC'D BY REGISTRAR OCT 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

14541

14541

Washington, D. C.

10 years

John D. M. (husband)

Wash. State, D. C.

Wash. State, D. C.

10 years

10

Wash. State, D. C.

Wash. State, D. C.

10

Wash. State, D. C.

Wash. State, D. C.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14541 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14542									
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Prince George				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital					d. STREET ADDRESS 7815 B. St.				
3. NAME OF DECEASED (Type or print) First Middle Last Sheri Denise Carpenter					4. DATE OF DEATH Month 10 Day 14 Year 1966				
5. SEX F		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 14 Sept., 1966		9. AGE (in years last birthday) yrs. 10 Months 14 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Residence, Wash. D.C. Maryland Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William A. Carpenter					14. MOTHER'S MAIDEN NAME				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.		17. INFORMANT See #13		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 525X Interstitial pneumonitis Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Sudden death in infancy (c) OUE TO (d) OUE TO								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Kehoe, M.D., Riverdale				M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 10-16-66	
EXAMINER'S NAME (Type)				Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-66		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		23d. LOCATION (City, town or county) (State) Arlington, Va.			
24. FUNERAL DIRECTOR Frazier's - Washington, D. C.				ADDRESS		25a. REC'D BY REGISTRAR OCT 18 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14542

CERTIFICATE OF DEATH

14543

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 4208- 29th Street	
3. NAME OF DECEASED (Type or print) First Ellen Middle C. Last Catlett		4. DATE OF DEATH Month October 24, 19 66	
5. SEX Fe	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-29-92
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Tom Williams		14. MOTHER'S MAIDEN NAME Mitchell Bowie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Paul H Catlett, Mt Rainier, Md. & Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5391 Hemorrhage from Subcapsula Hemorrhage spleen DUE TO Pleural effusion, bilateral; Rt pneumonia 2 days (b) aspergillus from obstructed esophagus (c) from esophageal stricture + ulceration esophagus mouth PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10-14, 19 66 to 10-24, 19 66 that (I) (we) last saw the deceased alive on 10-24 19 66 and that death occurred at 4:25 PM, from causes and on the date stated above.			
22a. SIGNATURE Rowland F Wilkinson		22b. DATE SIGNED 10/25/66	
22c. PHYSICIAN'S NAME (Type) Rowland F Wilkinson		22d. ADDRESS Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 27, 1966	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. RECD BY REGISTRAR DATE OCT 27 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14543 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14544

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton c. LENGTH OF STAY IN 1b one hour d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Clinton Medical Center		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Virginia b. COUNTY Warrenton c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c/o Sp-5 Venhill Farm Station e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Palmer Elvin Christianson		4. DATE OF DEATH Month Day Year October 20 19 66	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter O. Christianson		14. MOTHER'S MAIDEN NAME Regina Boyd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 479-10-9712A	
17. INFORMANT David Christianson		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 4201 } DUE TO Congestive heart failure (b) Myocardial fibrosis (c) DUE TO Coronary arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH hours hours years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 10-21-66	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-27-1966	23c. NAME OF CEMETERY OR CREMATORY Story City Memorial
23d. LOCATION (City, town or county) Story City, Iowa		(State)	
24. FUNERAL DIRECTOR Robert A. Mattingly		131 11th St S.E. Wash, D.C.	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE OCT 24 1966			

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FOR STATE
HEALTH DEPT

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME
3500 4-64

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14544 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14545

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 37 Walnut Lane, Cherry Hill Traylor		d. STREET ADDRESS Traylor Park. 37 Walnut Lane, Cherry Hill	
3. NAME OF DECEASED (Type or print) First Middle Last Austin D Clark		4. DATE OF DEATH Month Day Year 10 9 19 66	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 Jan. 1889	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stereotypist		9. AGE (In years last birthday) 77 yrs.	
11. BIRTHPLACE (State or foreign country) Washington Post Newspaper Co. Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Austin		14. MOTHER'S MAIDEN NAME Celina M. Eoute	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577 03 2823	
17. INFORMANT Ruth H. Clark		Address Same as #2 (wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Heart failure DUE TO Arteriosclerotic heart disease (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 10-10-66	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF 10/12/66	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 13 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MEDICAL EXAMINER'S CERTIFICATE

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME
3500 4-64

FOR STATE
HEALTH DEPT.

14545

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14546

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b 4 hrs. 40min d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville d. STREET ADDRESS 4919 Naples Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Leslie Thomas Clark		4. DATE OF DEATH Month Day Year 10 12 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-6-1936
9. AGE (In years last birthday) 30 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) heavy equipment sand & gravel		10b. KIND OF BUSINESS OR INDUSTRY Bowie Md	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Lee Clark		14. MOTHER'S MAIDEN NAME Evelyn Rose Curtin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Grace Clark Beltsville Md	
17. INFORMANT Grace Clark Beltsville Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, left, subarachnoid and interventricular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 330X (b) Rupture of Berry aneurysm, left middle cerebral artery (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 10-13-66	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-15-66	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION (City, town or county) (State) Wheaton Md
24. FUNERAL DIRECTOR Mc Witt Danaldson Laurel Md		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 19 1966	

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Deputy Medical Examiner Notified: Dr. John Kehoe

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

14547

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md b. COUNTY Pro George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb Greenbelt, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marvin C. Cline		4. DATE OF DEATH Month Oct Day 25, Year 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1901
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Building		10b. KIND OF BUSINESS OR INDUSTRY contractor	
11. BIRTHPLACE (County & State, or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Alysses Cline		14. MOTHER'S MAIDEN NAME Alvina --	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 482 01 5551A	
17. INFORMANT Edna A Cline		Address Greenbelt, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 CARDIAC ARRHYTHMIA DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from APRIL, 1961, to 10-25, 1966 that (I) (we) saw the deceased alive on 10-21 1966 and that death occurred at 12:30 P.M. from causes and on the date stated above			
22a. SIGNATURE Morrill C. Quinman Jr.		22b. DATE SIGNED Oct 25, 1966	
22c. PHYSICIAN'S NAME (Type) Morrill C. Quinman Jr.		22d. ADDRESS Silver Springs, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 28, 1966	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 27 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CONFIDENTIAL

Name		Address	
Last Name		First Name	
Middle Name		Suffix	
Date of Birth		Place of Birth	
Sex		Race	
Religion		Education	
Occupation		Marital Status	
Current Address		Previous Address	
City		State	
Zip		Country	
Telephone		Fax	
Email		Social Security	
Identification		Signature	
Date		Time	
Location		Remarks	

CONFIDENTIAL

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Items 18-21 Film 381
10-13-66 am
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14547 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14548

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 6110 43rd Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John First P. Middle Last Clum		4. DATE OF DEATH October 2 19 66 Month Day Year					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/10	9. AGE (In years last birthday) 56 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Cornelius W. Clum		14. MOTHER'S MAIDEN NAME Mary Greer Herring			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220 44 1853		17. INFORMANT Katherine G. Clum Address Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized toxemia 855X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) peritonitis from sigmoid diverticulum DUE TO (c) blunt trauma to abdomen PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on a boat					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 9-11 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) boat			
20f. (City or town) Indian River Inlet		20g. (County) Del.		20h. (State) Del.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> 16-4 GC ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 5318 Annapolis DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5318 Annapolis Address (Street, city, town, or county) <input type="checkbox"/> 5318 Annapolis							
ACTUAL SIGNATURE Dayton O Watkins		22. DATE SIGNED 5318 Annapolis Bledinsbury rd					
EXAMINER'S NAME (Type) DAYTON O WATKINS		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
23b. DATE THEREOF Oct. 5, 1966		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City, town or county) Rockville, Mont. Co. Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons, Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14548		CERTIFICATE OF DEATH				14549			
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs 16-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital					d. STREET ADDRESS 5704 Old Branch Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle R. Last Colegrove					4. DATE OF DEATH Month October Day 23 Year 19 66				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 16, 1895		9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Salesman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William R. Colegrove					14. MOTHER'S MAIDEN NAME Emma Rabbit				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address William C. Colegrove 3416 Brinkley Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1420 Carcinoma of parotid gland, left Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) @ metastasis to lymph nodes of neck (c) + mediastinal								INTERVAL BETWEEN ONSET AND DEATH 6 m.p. -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 9-12, 1966, to 10-23, 1966, that (I) (we) last saw the deceased alive on 10-14, 1966, and that death occurred at 6:00 A.M. from causes and on the date stated above.									
22a. SIGNATURE John P. D'Angelo M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-24-66		
22c. PHYSICIAN'S NAME (Type) John P. D'Angelo M.D.					22d. ADDRESS 3508 Branch Ave.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-26-66		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City or Town) (County) (State) Arlington Virginia		
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd Suitland Maryland					25a. REC'D BY REGISTRAR DATE OCT 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

14530

UNITED STATES

14530

[Faint, mostly illegible text and markings on a form, possibly a certificate or official document. Some visible words include "UNITED STATES", "CERTIFICATE", and "No. 14530".]

[Vertical text on the right margin, mostly illegible. Some visible words include "RECEIVED", "DATE", and "BY".]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14549						14550					
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington 47-3				d. STREET ADDRESS 1301 Vermont Avenue, N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Cornelia Cornell Compson			4. DATE OF DEATH Month Day Year October 9 19 66			5. SEX Female			6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Nov. 20, 1888			9. AGE (In years last birthday) 77 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretarial				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Lyons, New York			
12. CITIZEN OF WHAT COUNTRY? United States						13. FATHER'S NAME Mervin Matthew Compson					
14. MOTHER'S MAIDEN NAME Emma McGown						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown					
16. SOCIAL SECURITY NO. 578-03-4643						17. INFORMANT Sacred Heart Home, W. Hyattsville, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Hypertensive heart disease & congestive failure OUE TO (b) failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Oct 16, 1966, to Oct 9, 1966, that (I) (we) last saw the deceased alive on Oct 7, 1966, and that death occurred at 8 M, from the causes and on the date stated above.											
22a. SIGNATURE Thomas F. Collins MD						22b. DATE SIGNED 10-9-66			22c. PHYSICIAN'S NAME (Type) THOMAS F. COLLINS		
22d. ADDRESS 322-H ST. N.E., WASH., D.C.						22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10-13-66			23c. NAME OF CEMETERY OR CREMATORY —			23d. LOCATION (City, town or county) (State) LYONS, NEW YORK		
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS, 5130 WIS. AVE., N.W., WASHINGTON, D.C.						25a. REC'D BY REGISTRAR OCT 13 1966					
25b. REGISTRAR'S SIGNATURE Charles Judge											

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Office of the

Office of the

Washington

Washington

301 Vermont Avenue, N.W.

301 Vermont Avenue, N.W.

October 9, 1950

Dear Sir:

Enclosed

is a copy

of the report

of the committee

on the subject

of the

of the

of the

of the

Very truly yours,

Very truly yours,

Very truly yours,

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Pr. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel - Rural</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel - Rural</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Sherry Lane</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Grace</i> Middle <i>A. Connell</i> Last <i>Connell</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>29</i> Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/30/1882</i>
9. AGE (In years lost birthday) <i>83</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>PENNA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>James S. Smith</i>		14. MOTHER'S MAIDEN NAME <i>Camelia E.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>577-09-7765-B</i>	
17. INFORMANT <i>Thomas B Connell</i> Address <i>same as above</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocarditis</i> 4222 DUE TO (b) <i>Chronic Myocarditis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>11/1</i> 19 <i>65</i> , to <i>10/29</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>10/29</i> 19 <i>66</i> , and that death occurred at <i>9PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert S. Macaney</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Laurel, Md. Robert S. Macaney M.D.</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>2 November 1966</i>	23c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NATIONAL CEM.</i>	23d. LOCATION (City, town, or county) (State) <i>ARLINGTON, VIRGINIA</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Harold S. Wade</i> ADDRESS <i>550 Wash. Blvd. Laurel, Maryland</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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CERTIFICATE OF AID

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14551

14552

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Jacob Last Corman		4. DATE OF DEATH Month 10 Day 23 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-5-84
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 16 Days 1 Hours 1 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Farmer		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Corman		14. MOTHER'S MAIDEN NAME Catherine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Eloise C. Boyette		Address Maryland 5632 Fargo Ave Oxon Hill	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>		22. DATE SIGNED 10-24-66	
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-28-66	
23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Cole Camp Missouri	
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd Suitland Maryland		25a. REC'D BY REGISTRAR OCT 27 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14552

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>DC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eugene Leland Mem Hosp</u>				d. STREET ADDRESS <u>1305 Savannah St. S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maudie</u> Middle <u>Taylor</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>October</u> Day <u>24</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>5/21/1886</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. H. Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Townsend</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>416-09-0480</u>		17. INFORMANT <u>Elizabeth Crowson</u>		Address <u>Same #7</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>+ 1 week</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>April 5</u> , 19 <u>65</u> , to <u>October 24</u> , 19 <u>66</u> , that (I) was last saw the deceased alive on <u>October 23</u> , 19 <u>66</u> , and that death occurred at <u>6:40</u> M, from causes on and on the date stated above.							
22a. SIGNATURE <u>Walcutt W. Gibson</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Oct. 24-1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Walcutt W. Gibson, M.D.</u>				22d. ADDRESS <u>4300 St. Barnabas Road Marlow Heights, Maryland 20851</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-27-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Alta Vista Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Gainesville, Georgia</u>	
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>				ADDRESS <u>1661-Good Hope Rd SE Wash DC</u>		25a. REC'D BY REGISTRAR <u>OCT 25 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CONTRACT NO. 14553

TO THE
HONORABLE
MEMBERS OF THE
HOUSE OF REPRESENTATIVES
AT WASHINGTON
D.C.
THE
COMMISSIONER OF THE
GENERAL LAND OFFICE
WASHINGTON
D.C.
SIR:
I HAVE THE HONOR TO ACKNOWLEDGE
YOUR LETTER OF THE 14TH INSTANT
IN REGARD TO THE MATTER OF THE
LANDS OF THE DISTRICT OF
COLUMBIA.
I HAVE BEEN ADVISED THAT THE
LANDS OF THE DISTRICT OF
COLUMBIA ARE NOW BEING
REDEVELOPED.
I AM SURE THAT THE
COMMISSIONER OF THE
GENERAL LAND OFFICE
WILL BE GLAD TO ASSIST
YOU IN ANY WAY POSSIBLE.
Yours very truly,
[Signature]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY ERIE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Erie d. STREET ADDRESS 1126 East 26th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Arthur Leroy Dedrick First Middle Last 5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER-BUCYRUS-ERIE CORP. 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) KANSAS CITY, KANSAS 12. CITIZEN OF WHAT COUNTRY? U.S.A.					4. DATE OF DEATH October 7 1966 Month Day Year 9. AGE (In years last birthday) 51 yrs. IF UNDER 1 YEAR: Months Days Hours Min. 13. FATHER'S NAME JOHN DEDRICK 14. MOTHER'S MAIDEN NAME IVA McCULLOUGH 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 175-09-5276 17. INFORMANT PAULINE DEDRICK, 1126 E. 26 ST., ERIE, PA. Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 OUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus over 20 years 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>John Kehoe</i> EXAMINER'S NAME (Type) John Kehoe, M.D. 22. DATE SIGNED 10-8-66 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)									
23a. BURIAL, CREMATION, or REMOVAL (Specify) 23b. DATE THEREOF 10-11-1966 23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY 23d. LOCATION (City, town or county) (State) MILLCREEK TWP., ERIE CO. PA. 24. FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE NALKEYS FUNERAL HOME 3200 RT. Ave. Mt Rainier Maryland OCT 11 1966 <i>Charles Judge</i>									

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14554

CERTIFICATE OF DEATH

14555

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berkshire		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berkshire	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3806 75 Avenue		d. STREET ADDRESS 3806 75 Avenue	
3. NAME OF DECEASED (Type or print) First Pasqua Middle Di Last Bartolo		4. DATE OF DEATH Month 10 Day 3 Year 1966	
5. SEX Female	6. COLOR OF RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1894
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 10 Days 3 Hours 19 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Manganaro		14. MOTHER'S MAIDEN NAME Josephine Manganaro	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Rose M. Mammano		Address 3806 75 Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 7, 1963 , to Oct. 3, 1966 , that (I) (we) last saw the deceased alive on June 14, 1963 , and that death occurred at 8:43 A.M. , from causes and on the date stated above.			
22a. SIGNATURE W.B. Sheer		22b. DATE SIGNED 10-3-66	
22c. PHYSICIAN'S NAME (Type) WALTER B. SHEER		22d. ADDRESS 6400 MARLBORO PIKE S.E. District Heights, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/5/66	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington D. C.
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd., Suitland Md.		25a. REC'D BY REGISTRAR DATE OCT 6 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14552

14552

CERTIFICATE OF DEATH

[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]

[Vertical text on the right margin, likely a filing or archival note.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14555					14556				
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillside			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillside			d. STREET ADDRESS 1325--56th Ave., S. E.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1325--56th Ave., S. E.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First MIDDLE LAST LINA M. DiGiulian			4. DATE OF DEATH Month Day Year Oct. 24th 19 66						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 Jan. 1902		9. AGE (In years last birthday) 64 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Italy			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME XXXXXX John Tron					14. MOTHER'S MAIDEN NAME Jeanne Pascal				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Alfeo P. DiGiulian Same as Item #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1530 Carcinomatous Generalized DUE TO (b) Carcinoma of Cecum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 1 year 18 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1959, 19, to 10/24, 1966, that (I) (we) last saw the deceased alive on 10/23, 1966, and that death occurred at 5 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Chas. V. Pate					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Oct. 24-1966		
22c. PHYSICIAN'S NAME (Type) Dr. Charles V. Pate					22d. ADDRESS 335--W--St., N. E. Wash. DC				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 27-1966		23c. NAME OF CEMETERY OR CREMATORY Presbyterian Cem.		23d. LOCATION (City, town or county) (State) Valdese, North Carolina			
24. FUNERAL DIRECTOR Simmons Bros					25a. REC'D BY REGISTRAR DATE OCT 25 1966				
25b. REGISTRAR'S SIGNATURE J Charles Judge									

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Dr. Charles V. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			c. LENGTH OF STAY IN 1b 9 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4206 - 31st St.					d. STREET ADDRESS 4206 - 31st St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Otis First H. Middle Easterday Last					4. DATE OF DEATH Month 10 / Day 1 / Year 1966				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/22/1887		9. AGE (In years last birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. Easterday					14. MOTHER'S MAIDEN NAME Annie Parsons				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 231-38-5803-A		17. INFORMANT Address Mrs. Mary E. Easterday (above ad-)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency 5271 DUE TO (b) Pulmonary emphysema + fibrosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH. 2 months 4-5 years	
2da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
2dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			2dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		2de. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2df. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7-16, 1966 to 10-1, 1966 that (I) (we) last saw the deceased alive on 9-30, 1966 and that death occurred at 5:00 M, from the causes and on the date stated above.									
22a. SIGNATURE Jason Geiger, M.D.					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-1-66		
22c. PHYSICIAN'S NAME (Type) Jason Geiger, M.D.					22d. ADDRESS 800 - Pershing Dr. Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/4/66		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.			
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.					25a. REC'D BY REGISTRAR DATE OCT 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14557					14558				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>Prince Georges</u> MARYLAND					a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>				
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>					d. STREET ADDRESS <u>9109 Springhill Lane</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges County Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Robert Clay</u>			First Middle Last		4. DATE OF DEATH <u>October 22 1966</u>		Month Day Year		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 3, 1906</u>		9. AGE (In years last birthday) <u>60</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nat'l Dir. Disaster Serv. Amer. Red Cross</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>St. Joseph, Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Walter Edson</u>					14. MOTHER'S MAIDEN NAME <u>Katherine Drake</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Ruth Edson</u>		Address <u>9109 Springhill Lane Greenbelt, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> <u>2 months.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
2Da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>9-23/66</u> , 19 <u>66</u> , to <u>10/22/66</u> , that (I) (we) last saw the deceased alive on <u>10/14</u> , 19 <u>66</u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Louis Ross</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/24/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Louis Ross, M.D.</u>					22d. ADDRESS <u>1712 Eye St. NW, Wash. DC, 20006</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 26, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>			
24. FUNERAL DIRECTOR <u>Clark E. Wison</u> <u>Warner E. Humphrey, Inc.</u>					ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 27 1966</u>		
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

7224

2264

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14558

CERTIFICATE OF DEATH

14558

1. PLACE OF DEATH a. COUNTY <u>Prince Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Geo. General Hospital</u>		d. STREET ADDRESS <u>6005 38 Place</u>	
3. NAME OF DECEASED (Type or print) <u>Edith M Edwards</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>22</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1907</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u> Hours <u>56</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during year before death, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>William Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>214 30 0705</u>	
17. INFORMANT <u>L. D. Edwards</u>		Address <u>Same as #2 (husband)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Insufficiency</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Arteriosclerosis</u> DUE TO (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary edema; Bilateral hydropneumothorax</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/21</u> , 19 <u>66</u> , to <u>10/22/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/22</u> , 19 <u>66</u> , and that death occurred at <u>7:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Reginald Hughes</u> M.D.		22b. DATE SIGNED <u>10/23/66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/26/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor P.G. Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasche Sons</u>		25a. REC'D BY REGISTRAR <u>John Charles Judge</u>	
ADDRESS <u>Hyattsville, Md</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	
DATE <u>OCT 26 1966</u>			

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1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14559

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14560

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine 16-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS Box 71		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Warren Middle Patrick Last Edwins			4. DATE OF DEATH Month 10-7-66 Day 19 Year 19				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 July 1953		9. AGE (In years last birthday) 13 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY SCHOOL		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM EDWINS				14. MOTHER'S MAIDEN NAME SHASTA SMITH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address WILLIAM EDWINS, BRANDYWINE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8124 Laceration of brain, and Fracture of rt. femur, Trauma-auto accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO							INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by car while walking along road.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:36 p.m. 10 7 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) St. rt. 381 Brandywine, P.G.		20f. (City or town) (County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		22. DATE SIGNED 10-9-66		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-12-66		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT.		23d. LOCATION (City, town or county) (State) ARLINGTON, VA.	
24. FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf, Md.				25a. REC'D BY REGISTRAR DATE OCT 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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WILLIAM EDWARDS
JAMES A. SMITH
JAMES A. SMITH
JAMES A. SMITH

WILLIAM EDWARDS

WILLIAM EDWARDS
JAMES A. SMITH
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JAMES A. SMITH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BELTSVILLE c. LENGTH OF STAY IN 1b 16-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11330 CHERRY HILL ROAD		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BELTSVILLE d. STREET ADDRESS 11330 CHERRY HILL ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE CLARK ELLIOTT		4. DATE OF DEATH Month Day Year Oct 25 1966	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 JUNE 1913
9. AGE (In years last birthday) 53		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD TRAINMAN	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME GEORGE C. ELLIOT	
14. MOTHER'S MAIDEN NAME BESSIE BRADY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. 719 01 3047		17. INFORMANT G. CLARK ELLIOTT Address 4604 WICUMICO AV BELTSVILLE, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH minutes 6 years.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 1926 , to 1966 , that (I) (we) lost the deceased alive on October 25 1966 , and that death occurred at 10 P.M. , from causes and on the date stated above.	
22a. SIGNATURE Hans Wodak M.D.		22b. DATE SIGNED 10-26-1966	
22c. PHYSICIAN'S NAME (Type) HANS WODAK M.D.		22d. ADDRESS GREENBELT, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 28 Oct 1966	
23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION (City or Town) (County) (State) WHEATON, MARYLAND	
24. FUNERAL DIRECTOR W.W. Chambers Co. Pivierdale, Maryland		25a. REC'D BY REGISTRAR DATE OCT 31 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

14501

CRIMINALS OF DOCTRINE

14500

CONTINUED FROM PAGE 14499

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14561			CERTIFICATE OF DEATH				14562		
1. PLACE OF DEATH a. COUNTY Prince Georg'es b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 2 mo. 13 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville d. STREET ADDRESS 10405A 46th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Dorothy L. Emard					4. DATE OF DEATH Month Day Year October 13 1966				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 7, 1927		9. AGE (In years last birthday) 39 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY SECRETARIAL		11. BIRTHPLACE (County & State, or foreign country) La Junta, Colorado			12. CITIZEN OF WHAT COUNTRY? UNITED STATES		
13. FATHER'S NAME OTIS FLINN					14. MOTHER'S MAIDEN NAME BERYL CLIFFORD				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 524-24-9329		17. INFORMANT (Husband) Beltsville, Maryland LeRoy Emard 10405-A, 46th Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO Carcinoma of the Esophagus & Carcinoma of the Rectum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Jan 2, 1966 , to Oct 13, 1966 , that (I) (we) last saw the deceased alive on 9-13-66 , and that death occurred at 11:45M , from causes and on the date stated above.									
22a. SIGNATURE Aaron Deitz					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. pm		22b. DATE SIGNED 10/14/66		
22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M.D.					22d. ADDRESS Hyattsville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/17/1966		23c. NAME OF CEMETERY OR CREMATORY La JUNTA, COLORADO		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR HYSOING'S FUNERAL HOME-1300 N.ST., N.W.					25a. REC'D BY REGISTRAR DATE OCT 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

14565

14565

UNITED STATES OF AMERICA

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FOR STATE
HEALTH DEPT.

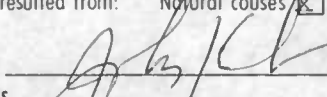
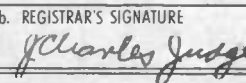
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14562

14563

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 45min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 3819 37th. Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary S Fisher				4. DATE OF DEATH Month Day Year 10 29 19 66			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 May 1894		9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick W. Carress				14. MOTHER'S MAIDEN NAME Mary Walsh			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-46-2260		17. INFORMANT Address 13209 - Mrs. Catherine F. Hewlett - Taney Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO				(Daughter) Beltsville, Md. INTERVAL BETWEEN ONSET AND DEATH minutes unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Diabetes - known over 2 years				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				22. DATE SIGNED 10-30-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/2/66		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				25. REC'D BY REGISTRAR ADDRESS Mt. Rainier Maryland DATE NOV 4 1966		25b. REGISTRAR'S SIGNATURE 	

14503

14503

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14563

14564

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL RFD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1924 SANDY SPRING RD</u>		d. STREET ADDRESS <u>1924 SANDY SPRING RD</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN FREDERICK FLESTER SR</u>		4. DATE OF DEATH <u>OCTOBER 25</u> 19 <u>66</u>	
5. SEX <u>MALE CAUC</u>	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 17, 1879</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RET.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ANDREW FLESTER</u>		14. MOTHER'S MAIDEN NAME <u>MARY AITCHESON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS MARGARET FLESTER</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia, Rt. Lower and middle lobes.</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis.</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Oct 24</u> 19 <u>66</u> , and that death occurred at <u>1:30</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Robert C. Wingfield</u>		22b. DATE SIGNED <u>10/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD, M.D.</u>		22d. ADDRESS <u>329 PRINCE GEORGE STREET</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>OCT 28, 66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>IVY HILL CEM</u>	23d. LOCATION (City or Town) (County) (State) <u>LAUREL MARYLAND</u>
24. FUNERAL DIRECTOR <u>HAROLD S. WADE, LAUREL MARYLAND</u>		25a. REC'D BY REGISTRAR <u>OCT 26 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14264

TECHNICAL DATA

14264

THIS DOCUMENT CONTAINS INFORMATION OF A CONFIDENTIAL NATURE AND IS NOT TO BE RELEASED TO THE PUBLIC OR TO ANY OTHER AGENCY OR INDIVIDUAL WITHOUT THE WRITTEN AUTHORIZATION OF THE SECRETARY OF COMMERCE.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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Exp

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14564

14565

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
c. LENGTH OF STAY IN 1b 6 days		d. STREET ADDRESS 4111 Rainier Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Helen D Flick		4. DATE OF DEATH Month 10 Day 11 Year 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-26-1890
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXAMINER		10b. KIND OF BUSINESS OR INDUSTRY BOQ ENG U.S.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME EDWARD SAGE		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214 32 9043	
17. INFORMANT CARLTON R. FLICK		Address 6517 PERSIMMON TREE RD. CABIN JOHN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia 8120 DUE TO From Mallory - Weiss syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) And Fracture right femur, right tibia and right fibula DUE TO (c) From Trauma Auto accident		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Pedestrian struck by truck	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10-5-1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8th. & D. Sts., N.W. Washington, D.C.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 10-11-66	
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-14-1966	
23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM.		23d. LOCATION (City, town or county) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR W.W. Chambers Co., Riverdale, Md.		25a. REC'D BY REGISTRAR DATE OCT 19 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

See Film G381- 10/19/66- MB
Originally reported on regular death cert. and
should have been on M.F.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14565

CERTIFICATE OF DEATH

14567

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMP SPRINGS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SOUTHERN MARYLAND HOSP. CENTER</u>		d. STREET ADDRESS <u>8504 Allentown Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>EDWIN</u> First <u>M.</u> Middle <u>FOSTER</u> Last		4. DATE OF DEATH <u>OCT.</u> Month <u>9</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN-25-1914</u> 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ST. ELIZABETH'S HOSPITAL</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>KING GEO. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest W. Foster</u>		14. MOTHER'S MAIDEN NAME <u>Eunice Hudson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW-11</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss Louise E. Foster #2</u> Address <u>Same as</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE WITH PULMONARY EDEMA</u> DUE TO (b) <u>ANTERIOR MYOCARDIAL INFARCTION</u> DUE TO (c) <u>HYPERTENSIVE ARTERIOSCLEROTIC CV DISEASE</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</u> <u>18 HOURS</u> <u>3 YRS.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year <u>None</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> of work <u>None</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT 29, 1966</u> to <u>PRESENT</u> , that (I) (we) last saw the deceased alive on <u>10/9/66</u> , and that death occurred at <u>8:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Shaver Jr.</u>		22b. DATE SIGNED <u>10/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR.</u>		22d. ADDRESS <u>8808 BRANCH AVE., CLINTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 12-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>Simmons Bros.</u> ADDRESS <u>1661-Gd. Hope Rd. SE. Wash., DC</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 13 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PAGE 2

1528

5/24/94 : 11:11:00

10-11-1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

96

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (Specify)

24. FUNERAL DIRECTOR

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14566

14568

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE -- b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Regent Nursing Home		d. STREET ADDRESS 3035 30th. St., S.E.	
3. NAME OF DECEASED (Type or print) First MARGUERITE Middle FULLER Last FULLER		4. DATE OF DEATH Month October Day 13 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1893
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 2 Days 4 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY D.C.	
11. BIRTHPLACE (County & State, or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael F. Bolger		14. MOTHER'S MAIDEN NAME Cora Langley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Margaret Abell-4006 E Cap. Street DC	
17. INFORMANT Margaret Abell-4006 E Cap. Street DC		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition, anemia 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Myeloma DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 months 1-2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/24 , 19 66 , to 10/13 , 19 66 , that (I) (we) last saw the deceased alive on 10/13 , 19 66 , and that death occurred at 5:20 P.M., from causes and on the date stated above.			
22a. SIGNATURE Frank J. Fedor		22b. DATE SIGNED 10/13/66	
22c. PHYSICIAN'S NAME (Type) FRANK J. FEDOR		22d. ADDRESS 4201 Cathedral Ave N.W. DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/17/66	23c. NAME OF CEMETERY OR CREMATORY Wash. National	23d. LOCATION (City or Town) (County) (State) Suitland, Md.
24. FUNERAL DIRECTOR Has. T. Ryan, Inc.		25a. REC'D BY REGISTRAR OCT 17 1966	
ADDRESS 317 Pa. Ave., SE DC		25b. REGISTRAR'S SIGNATURE Charles Judge	

VR A15 (4)
20 M 1/66

14502

14502

White House

Washington, D.C.

and the White House

3033 30th St., N.W.

CONGRATULATE

October 13, 1961

Female White

Feb. 11, 1962

Female

D.C.

John F. Kennedy

John F. Kennedy

No

John F. Kennedy

John F. Kennedy

John F. Kennedy

John F. Kennedy

John F. Kennedy

John F. Kennedy

John F. Kennedy

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14567

CERTIFICATE OF DEATH

14569

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEORGE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ADELPHI</u>		c. LENGTH OF STAY IN 1b <u>6 DAYS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PAINT BRANCH NURSING HOME</u>		d. STREET ADDRESS <u>11272 EVANS TRAIL</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLOTTE Haddick</u> <u>Fullerton</u>		4. DATE OF DEATH Month Day Year <u>Oct. 9 1966</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>FEB. 17, 1980</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Haddick</u>		14. MOTHER'S MAIDEN NAME <u>? Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>326-30-7243</u>	
17. INFORMANT <u>Robert Dyas</u>		Address <u>11272 Evans Trail, Beltsville Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221 Congestive heart failure</u> DUE TO (b) <u>Generalized arteriosclerotic cardiovascular disease 1-2 yrs.</u> DUE TO (c) <u>E. cerebral deterioration</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>1964</u> , 19 <u>64</u> , to <u>9 Oct</u> , 19 <u>66</u> that (1) (not) last saw the deceased alive on <u>9 Oct</u> , 19 <u>66</u> , and that death occurred at <u>12:00 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Ernest E. Harmon</u>		22b. DATE SIGNED <u>9 Oct 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ernest E. Harmon</u>		22d. ADDRESS <u>9301 Colesville Rd., S.S., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 13, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Western Township Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Henry County, Illinois</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>OCT 14 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1-1500

1-1500

1-1500

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1M

MD
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14568

14570

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b 16-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale d. STREET ADDRESS 5706 Kennedy Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George W. Goodwin		4. DATE OF DEATH Month Day Year October 6, 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-1-95
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAN		10b. KIND OF BUSINESS OR INDUSTRY Office	
11. BIRTHPLACE (County & State, or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 413092711	
17. INFORMANT Medical Record/S.C. Winburn/Wife's uncle		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) General arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks undetermined	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 22, 1966 , to Oct 6, 1966 , that (I) (we) last saw the deceased alive on Oct 5, 1966 , and that death occurred at 7:55 AM , from causes and on the date stated above.			
22a. SIGNATURE L.W. Malin		22b. DATE SIGNED 10/6/66	
22c. PHYSICIAN'S NAME (Type) L. W. Malin, M. D.		22d. ADDRESS 4404 Queensbury Road, Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-8-66	
23c. NAME OF CEMETERY OR CREMATORY FT LINCOLN CEM		23d. LOCATION (City or Town) (County) (State) BLADENSBURG MD	
24. FUNERAL DIRECTOR W.W. Chambers Co RIVERDALE, MD		25a. REC'D BY REGISTRAR DATE OCT 10 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

14530

14530

INSTRUMENT OF TRANSFER

NOTARIAL PUBLIC

NOTARIAL PUBLIC

STATE OF TEXAS

STATE OF TEXAS

THIS INSTRUMENT OF TRANSFER

WAS FILED FOR RECORD

ON THE 14TH DAY OF

1953

AT THE COUNTY CLERK'S

OFFICE

IN THE

COUNTY OF

TEXAS

NOTARY PUBLIC

NOTARIAL PUBLIC

NOTARIAL PUBLIC

IN WITNESS WHEREOF, I have hereunto set my hand and seal

IN WITNESS WHEREOF, I have hereunto set my hand and seal

NOTARY PUBLIC

NOTARY PUBLIC

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14569

CERTIFICATE OF DEATH

16063

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS --	
3. NAME OF DECEASED (Type or print) First Robert Middle Chalmers Last Goshorn		4. DATE OF DEATH Month October Day 26 , Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1881
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min. 85	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Goshorn		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ----	
17. INFORMANT James D. Goshorn-Same as Item #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion - DUE TO 5271 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Emphysema DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1962 , 19 Oct. 26 , 19 66 that (I) (we) last saw the deceased alive on Oct 22 1966 and that death occurred at 2:11 PM , from causes and on the date stated above.		22a. SIGNATURE Salvatore M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. DATE SIGNED 10/26/66		22c. PHYSICIAN'S NAME (Type) Salvatore	
22d. ADDRESS St. Leonard, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 10/29/66		23c. NAME OF CEMETERY OR CREMATORY Immanuel Cemetery	
23d. LOCATION (City or Town) (County) (State) Horsehead, Maryland		24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.	
25a. REC'D BY REGISTRAR NOV 10 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

10083

1456

Pr. George

Maryland

Prince George

Adams

1808

Obituary

X

--

Prince George General Hospital

October 24, 1808

Adams

Robert

Robert

82

June 10, 1801

X

White

White

U. S. A.

Pennsylvania

Om. Term

Tobacco Farming

Unknown

General Hospital

James D. Johnson - 1808

10

82

Oct. 25, 1808

1808

10/20/00

St. Leonard, Maryland

General Cemetery, St. Leonard, Maryland

1/23/00

Burial

Rhode Cross, Upper Marlboro, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14570

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14571

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Hgts. (College Park)	
c. LENGTH OF STAY IN 1b 4-days		d. STREET ADDRESS 5914-Natasha Dr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr. Geo. Gen. Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Percy Middle Abner Last Grant		4. DATE OF DEATH Month Oct. Day 27 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1916
9. AGE (In years lost birthday) yrs. 50		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Model Maker		10b. KIND OF BUSINESS OR INDUSTRY Goddard Space Agy.	
11. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? Yes	
13. FATHER'S NAME Abner Grant		14. MOTHER'S MAIDEN NAME Cora	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW2		16. SOCIAL SECURITY NO. 006-09-9858	
17. INFORMANT Mary J. Grant (Wife) same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral-cerebellar and midbrain infarction DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rt. internal carotid artery thrombosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 10-29-66		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Beverdale Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/1/66	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Virginia	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR OCT 31 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

17311

17311



1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14571 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14572

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN Id DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine d. STREET ADDRESS Rt. 1, Box 421 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lawrence Emory Gray		4. DATE OF DEATH Month 10 Day 10 Year 1966	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-1903
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (State or foreign country) Prince George's Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles M. Gray		14. MOTHER'S MAIDEN NAME Bertha A. Proctor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 4201	
17. INFIRMANT Bowell Gray		Address Rt. 1-Box 421 Brandywine, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 DUE TO Coronary occlusion, left anterior descending branch (b) Arteriosclerotic heart disease (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
22. DATE SIGNED 10-11-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-13-66	
23c. NAME OF CEMETERY OR CREMATORY St. Peters Church Cem.		23d. LOCATION (City, town or county) (State) Waldorf, Maryland	
24. FUNERAL DIRECTOR Martell Adams		ADDRESS Aguasco, Md.	
25a. REC'D BY REGISTRAR OCT 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

14573

14573

GENERAL EXAMINER'S CERTIFICATE OF RESULTS

TO THE
SCHOOL OF

Blank area for handwritten text and signatures.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Items #13 & 14 Film #G382 10/26/66 pc									
14572					14573				
1. PLACE OF DEATH a. COUNTY Prince George's					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Rowland GARCIA Griffith					4. DATE OF DEATH Month Day Year October 13 19 1966				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 16, 1898		9. AGE (In years last birthday) 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECURITY GUARD		10b. KIND OF BUSINESS OR INDUSTRY G.S.A. U.S.		11. BIRTHPLACE (County & State, or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME WILLIAM M. GRIFFITH					14. MOTHER'S MAIDEN NAME UNKNOWN // Melissa Walcott Griffith				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W.I		16. SOCIAL SECURITY NO. 219-34-7925		17. INFORMANT MARY LOIS GRIFFITH		Address SAME AS #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) MYOCARDIAL INFARCTION DUE TO (c) UREMIA								INTERVAL BETWEEN ONSET AND DEATH 10-1-66	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) UREMIA								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1950 to 10-13- 19 66 , that (I) (we) last saw the deceased alive on 10-13- 19 66 , and that death occurred at 9:20 PM , from causes and on the date stated above.									
22a. SIGNATURE Albert Roth					22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Albert Roth, M.D.		
22d. ADDRESS 5409 Riverdale Rd., Riverdale, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-18-1966		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA			
24. FUNERAL DIRECTOR W.W. Chambers Co Riverdale, Md.					25a. REC'D BY REGISTRAR DATE OCT 18 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

14233

MINUTE OF MEETING

14233

Finance Committee

Honorable

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14573					14574						
1. PLACE OF DEATH a. COUNTY <i>Pr. Georges</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Pr. Georges</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rogers Heights</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rogers Heights (Hyattsville P. O.)</i>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>5624 Elberton Place</i>					d. STREET ADDRESS <i>5624 Elberton Place 16-1</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>JOSEPH SCOTT Hartley</i>			4. DATE OF DEATH Month <i>Oct</i> Day <i>22</i> Year <i>1966</i>								
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 22, 1912</i>		9. AGE (In years last birthday) <i>54</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Building</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Montana</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Lewis Hartley</i>					14. MOTHER'S MAIDEN NAME <i>Cally Hash</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16. SOCIAL SECURITY NO. <i>214 03 0267</i>		17. INFORMANT <i>Mary W. Hartley Same as #2 (wife)</i> Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary atherosclerosis</i> <i>4201</i> DUE TO (b) <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i> <i>1 day</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10/1</i> , 1965, to <i>10/22</i> , 1966, that (I) (we) last saw the deceased alive on <i>10/22</i> , 1966, and that death occurred at <i>9A</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Robert S. McCleary</i>										22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>ROBERT S. MCCLEARY, M.D.</i> <i>402 MAIN ST.</i> <i>LAUREL, MARYLAND 20810</i>					22d. ADDRESS		MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>10/25/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bel Air Memorial Park</i>		23d. LOCATION (City, town or county)		(State)			
<i>Burial</i>						<i>Hartford County, Md.</i>		<i>Md.</i>			
24. FUNERAL DIRECTOR <i>Francis Gasch's Sons</i> ADDRESS <i>Hyattsville, Maryland</i>					25a. REC'D BY REGISTRAR DATE <i>OCT 24 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>				

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Analysis, synthesis and classifications

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14574

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14575

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 8 HRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Doris Middle Ann Last Hartman		4. DATE OF DEATH Month 10 Day 27 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-2-1916
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INVALID		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME THEODORE R. HARTMAN SR		14. MOTHER'S MAIDEN NAME ELSIE E. GRIGSBY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT THEODORE R. HARTMAN SR		Address 3200 VARNUM ST. MT. RAINIER, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hemorrhage - rt. frontal parietal area DUE TO 9040 (b) Trauma - fall in bathroom DUE TO 8 hrs. (c) 8 hrs.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral palsy 20 years		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in bathroom.	
20c. TIME OF INJURY Month, Day, Year 8:00 AM 10-27-66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Same as 2	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 10-28-66	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-31-66	
23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM		23d. LOCATION (City or Town) (County) (State) WASHINGTON DC	
24. FUNERAL DIRECTOR W.W. Chambers Co		ADDRESS RIVERDALE, MD	
25a. REC'D BY REGISTRAR NOV 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14576

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Emma Katherine Hayes		4. DATE OF DEATH Month Day Year October 20 1966	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Washington, DC.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Joy		14. MOTHER'S MAIDEN NAME Emma Bartlett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Evelyn G. Hayes (Dau.) Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus over 10 years		INTERVAL BETWEEN ONSET AND DEATH minutes over 10 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 10-20-66 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) Pivotala, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 22-66	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Simmons Bros. - 1661- Good Hope Rd. SE. Wash., DC		25a. REC'D BY REGISTRAR DATE OCT 24 1966	
		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14576

CERTIFICATE OF DEATH

14577

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 8 mos 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle Hayes Last Hayes		4. DATE OF DEATH Month October Day 13 Year 19 66	
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/28/1915
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 50 Days 50 Hours 50 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Parking Attend.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Raleigh, N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Hayes		14. MOTHER'S MAIDEN NAME Ida Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 578-07-2138	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Volvulus, small intestine DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Peritoneal adhesions DUE TO (c) Peritoneal adhesions		INTERVAL BETWEEN ONSET AND DEATH 1 day unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Bronchial aspiration of gastric contents; diabetes mellitus; diverticulosis; chronic urinary tract infection		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from 2/7/ , 1966, to 10/13/ , 1966, that he (we) lost the deceased alive on 10/13/ 19 66 , and that death occurred at 9:00AM , from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 10/13/66	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/17/66	
23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION (City or Town) (County) (State) Maryland	
24. FUNERAL DIRECTOR Stewart Funeral Home		25a. REC'D BY REGISTRAR John T. Stewart	
25b. REGISTRAR'S SIGNATURE John T. Stewart		25c. DATE OCT 18 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CRIMINAL OF DEATH

D.C.

Prince Georges

Washington

U. S. Army

Glenn Dale (travel)

Glenn Dale, D.C.

Glenn Dale Hospital

October 15

Hayes

Henry

12/24/1912

male negro

Glenn Dale, D.C.

Glenn Dale, D.C.

Ida William

William Hayes

Decedent

216-07-2132

no

Glenn Dale, D.C.

Glenn Dale, D.C.

10/13/1912

217

10/13/1912

10/13/1912

Glenn Dale Hospital
Glenn Dale, Maryland

Mr. Notes, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b Hyattsville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4708 Banner Street		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 4708 Banner Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWIN Middle T. Last HEHR		4. DATE OF DEATH Month OCT. Day 11, Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1870
9. AGE (In years day birthday) 96		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpet Layer	
11. BIRTHPLACE (County & State, or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM HEHR		14. MOTHER'S MAIDEN NAME MARY HEEB	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Marie F. Heyn		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4341 Congestive Heart failure DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 4/25/1933 , to 10/11/1966 , that (I) (we) last saw the deceased alive on 10/10/1966 , and that death occurred at 4:05 P.M. from causes and on the date stated above.	
22a. SIGNATURE F. E. Musser M.D.		22b. DATE SIGNED 10/11/66	
22c. PHYSICIAN'S NAME (Type) F. E. Musser, M.D.		22d. ADDRESS 4410 74th Ave Hyattsville	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/13/66	
23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR FRANCIS GASCH'S SONS ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 13 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1957

UNITED STATES DEPARTMENT OF AGRICULTURE

1957

Office of the Secretary

Washington, D.C.

Office of the Secretary

Department of Agriculture

Department of Agriculture

Washington, D.C.

Washington, D.C.

Office of the Secretary

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FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14578 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14579

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Upper Marlboro</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt 301</u>		e. STREET ADDRESS <u>Baumie</u> <u>16-1</u>	
3. NAME OF DECEASED (Type or print) <u>Bernard F. Heilig</u>		4. DATE OF DEATH <u>October 4</u> 19 <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1894</u> 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Fabian Heilig</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Lauer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-03-7093</u>	
17. INFORMANT <u>Mrs Bernard Heilig Baumie Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Occlusion of Circumflex Coronary Artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe Coronary Arteriosclerosis</u> (c) <u>4201</u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dayton O Watkins</u>		22. DATE SIGNED <u>10-4-66</u>	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		23. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5318 annapolis</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/8/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ascension Cemetery</u>		23d. LOCATION (City, town or county) <u>Baumie Maryland</u>	
24. FUNERAL DIRECTOR <u>McWitt Danaedson Laurel Md.</u>		25a. REG'D BY REGISTRAR <u>John Jones</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>OCT 13 1966</u>	

14578

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14579

14580

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Wash., DC.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Forestville</u>			c. LENGTH OF STAY IN 1b <u>5 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash., DC.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Regent</u>				d. STREET ADDRESS <u>3626 Alabama Ave SE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>HERRIMAN</u> Last <u>HERRIMAN</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>3</u> Year <u>19 66</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 1, 1888</u>		
9. AGE (In years last birthday) yrs. <u>78</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>ST. MARYS-CO. MD.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>LISA</u>				13. FATHER'S NAME <u>Melvin H. Herriman</u>				
14. MOTHER'S MAIDEN NAME <u>Mary Lyon</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				
16. SOCIAL SECURITY NO. <u>579-01-5941</u>				17. INFORMANT <u>Anna May Herriman Same as # 2</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO (b) <u>Essential Hypertension</u> DUE TO (c) <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>12 DAYS</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>50</u> , to <u>Oct 3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 2</u> , 19 <u>66</u> , and that death occurred at <u>4:20 AM</u> , from causes and on the date stated above.								
22a. SIGNATURE <u>William T. Saccardi</u>				22b. DATE SIGNED <u>10/3/66</u>		22c. PHYSICIAN'S NAME (Type) <u>William T. SACCARDI</u>		
22d. ADDRESS <u>1150 Conn Ave NW WASH DC</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>10-6-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Christ Episcopal</u>		23d. LOCATION (City or Town) (County) (State) <u>Chaptico, Md</u>		
24. FUNERAL DIRECTOR <u>Robert H. Hapthugly</u>				25a. REC'D BY REGISTRAR <u>131-11 St SE Wash DC</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11228

CERTIFICATE OF DEATH

11228

Blank certificate form with horizontal lines for text entry.

Vertical text on the right margin, likely a filing or processing stamp.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

Item 18 Film 387 4-13-67														
MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
14580														
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u> c. LENGTH OF STAY IN 1b <u>1 1/2 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> d. STREET ADDRESS <u>9702 48th Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Louisa K HERZOG</u>					4. DATE OF DEATH <u>October 2 19 66</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 19, 1886</u>		9. AGE (in years last birthday) <u>79</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Binder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U S Government</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D C</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>no</u>					17. INFORMANT <u>Margaret Dwyer</u> Address <u>College Park, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>570.5</u> IMMEDIATE CAUSE (a) <u>Electrolyte imbalance</u> DUE TO (b) <u>Intestinal obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>(Cause undetermined)</u>										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> ; Inspection <input checked="" type="checkbox"/> ; Inquiry <input checked="" type="checkbox"/> ; and in my opinion death resulted from: Natural causes <input type="checkbox"/> ; Accident <input type="checkbox"/> ; Suicide <input type="checkbox"/> ; Homicide <input type="checkbox"/> ; Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>Dayton O Watkins</u>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					22. DATE SIGNED <u>10-3-66</u>				
EXAMINER'S NAME (Type) <u>Dayton O Watkins</u>					Address (Street, city, town, or county) <u>10-3-66</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Oct 5, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			23d. LOCATION (City, town or county) (State) <u>Arlington Virginia</u>						
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>					25a. REC'D BY REGISTRAR <u>OCT 6 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

5318 Annapolis Rd.
Bladensburg, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14581

14582

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 7214 Nawthorne Terrace	
3. NAME OF DECEASED (Type or print) First Evelyn Middle E. Last Hill		4. DATE OF DEATH Month October Day 31 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/1890
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Dolan		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records		Address Cheverly, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 bronchopneumonia, Terminal DUE TO (b) arteriosclerotic heart disease DUE TO (c) lost Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1957 to 10/31 , 19 66 , that (I) (we) lost the deceased alive on 10/30 , 19 66 , and that death occurred at 10 AM from causes and on the date stated above.			
22a. SIGNATURE Dr. Peter Duus		22b. DATE SIGNED 10/31/66	
22c. PHYSICIAN'S NAME (Type) Dr. Peter Duus		22d. ADDRESS 6124 Central Ave., Capital Hgts., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov 3, 1966	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or town) (County) (State) Arlington Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE NOV 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Prince George's

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King Village

October 27, 1900

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14582

14583

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VA</u> b. COUNTY <u>WARREN</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>3 HRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRONT ROYAL</u>		83.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3713 KENNEDY STREET</u>				d. STREET ADDRESS <u>RIVERMONT DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES RALPH HILL</u>				4. DATE OF DEATH Month Day Year <u>OCT 8, 1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 10/1900</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUS OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. TRANSIT</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-10-6680</u>		17. INFORMANT <u>FRANCES L. HILL</u>		Address <u>RIVERMONT DRIVE, FRONT ROYAL, VA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/6</u> , 19 <u>66</u> , to <u>10/8</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/6</u> , 19 <u>66</u> , and that death occurred at <u>12:01</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Hilbert S. Sabin</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/8/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>HILBERT S. SABIN</u>				22d. ADDRESS <u>1712 E. 5th St. U.W.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/11/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BUCK VALLEY METH. CH.</u>		23d. LOCATION (City, town or county) (State) <u>WARFORDSBURG, PENNA.</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS Co. Riverdale, MD</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

14583

14583

Antennaria dioica
var. angustifolia

Antennaria dioica
14583
10/18/10

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14583

14584

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4-hrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Villa Hgts. (Bladensburg)		d. STREET ADDRESS 3805 56th. Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr. Geo. Gen. Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle L Last Hilton Sr.		4. DATE OF DEATH Month Oct. Day 28 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1906
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab driver		10b. KIND OF BUSINESS OR INDUSTRY Taxicab Company	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? Yes	
13. FATHER'S NAME Hilton		14. MOTHER'S MAIDEN NAME Mabel Butler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 577 03 1152	
17. INFORMANT Mary T. Hilton (Wife)		Address same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns - 50% of body surface DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 9160 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 4 hours
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Burned in house fire.	
20c. TIME OF INJURY Month, Day, Year 11:56 PM 10-27-66	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home same as in 2	
20f. (City or town) (County) (State) Bivendale, Md.		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 10-29-66	
EXAMINER'S NAME (Type) John Kehoe, M.D.		DEPUTY MEDICAL EXAMINER Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 31, 1966	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR OCT 31 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

14283

14283

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14584

CERTIFICATE OF DEATH

14585

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D. C. b. COUNTY 473			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)			c. LENGTH OF STAY IN 1b 1 mo. 27days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 221 33rd St., N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Solomon Middle A. Last Holmes				4. DATE OF DEATH Month October Day 6 Year 19 66			
5. SEX M		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/6/1910	
9. AGE (In years last birthday) 55 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
13. FATHER'S NAME Solomon A. Holmes				14. MOTHER'S MAIDEN NAME Catherine Greenleaf			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 579-12-5719		17. INFORMANT decedent Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic renal disease with insufficiency, etiology undetermined (c) Chronic alcoholism with Laennec's cirrhosis of liver							INTERVAL BETWEEN ONSET AND DEATH 3 mo. 2 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic alcoholism with Laennec's cirrhosis of liver							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/10/ 1966 , to 10/6/ 19 66 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/6/ 1966 , and that death occurred at 6:40PM , from causes and on the date stated above.							
22a. SIGNATURE <i>Moe Weiss</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		22b. DATE SIGNED 10/6/66	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-10-66		23c. NAME OF CEMETERY OR CREMATORY LINCOLN CEMETARY		23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR <i>W. S. Pope</i>				ADDRESS 414-15th St., S.E.		25a. REC'D BY REGISTRAR DATE OCT 11 1966	
				25b. REGISTRAR'S SIGNATURE <i>John J. Jones</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14522

UNION OF SOUTH

14522

Prince George

Washington, D.C.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14585

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14586

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN lb <u>13 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Leland Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Viola</u> Middle <u>BEATRICE</u> Last <u>Hooker</u>				4. DATE OF DEATH Month <u>10</u> Day <u>23</u> Year <u>19 66</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>29 Dec. 1888</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STENOGRAPHER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS EVELYN PEEBIN</u> Address <u>5402 QUINTANA ST RIVERDALE, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute bacterial endocarditis</u> <u>4300</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				22. DATE SIGNED <u>10-24-66</u>			
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>26 Oct 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON, VIRGINIA</u>	
24. FUNERAL DIRECTOR <u>W. W. Chambers Co. Riverdale, Md.</u> ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John Kehoe</u>	
DATE <u>OCT 26 1966</u>							

14286

14286

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14586

Items #11 & 17 Film #G387 3/22/67 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14582

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 7505 Citadel Drive			
3. NAME OF DECEASED (Type or print) First Liang Middle Hsu Last 4. DATE OF DEATH Month 10 Day 23 Year 19 66							
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Dec. 1911	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Librarian		10b. KIND OF BUSINESS OR INDUSTRY Library of Congress/		11. BIRTHPLACE (State or foreign country) China		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cheng Hsin Hsu				14. MOTHER'S MAIDEN NAME Unknown// Tu-lan Chen Hsu			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - - - -		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Florence P.C. Address Florence C. Hsu - Same as Item #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 443X DUE TO Hypertensive arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH minutes over 1 yr.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.		EXAMINER'S NAME (Type) John Kehoe, M.D.		M.D. Riverdale, Md.		22. DATE SIGNED 10-24-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-26-1966		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Prince Georges Co. Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. DC.				25a. REC'D BY REGISTRAR OCT 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

14323

14286

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14587

14588

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 14042 Willouby Drive				
3. NAME OF DECEASED (Type or print) First Middle Last Annie XXXXX A Huffman				4. DATE OF DEATH Month Day Year October 11 19 66				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10-1887		9. AGE (In years last birthday) yrs. 79 XXX	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Seamstress		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME XXXXXXXXXX Silas Talbert				14. MOTHER'S MAIDEN NAME Jessie Talbert				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Edna L. King Rt. #1, Box. 353 -Tippett Rd. Clinton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC DECOMPENSATION DUE TO 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO-SCLEROTIC HEART DISEASE DUE TO years (c) Pleural Effusion - unknown etiology unknown							INTERVAL BETWEEN ONSET AND DEATH years	
							PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1) Aortic aneurysm 2) Diabetes Mellitus	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
							20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
							20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 8, 1966 , to October 11, 1966 , that <input checked="" type="checkbox"/> (we) lost the deceased on October 11, 1966 , and that death occurred at 4:10 P.M. , from causes on and on the date stated above.								
22a. SIGNATURE Roger B. Ingham, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-12-66		
22c. PHYSICIAN'S NAME (Type) Roger B. Ingham, M.D.				22d. ADDRESS 5701 85th Ave. Carrolton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 14-66	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR Simmons Bros. Funeral Home				ADDRESS Wash., DC		25a. REC'D BY REGISTRAR DATE OCT 14 1966		
				25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8231

1508

1 (M)
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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14588

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14589

1. PLACE OF DEATH e. COUNTY <u>Prince George's</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Dale</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William</u> <u>Armstead</u> <u>Huston</u>		4. DATE OF DEATH Month Day Year <u>10</u> <u>10</u> <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 Nov. 1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delivery</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Huston</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Frey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>579-12-0079</u>	
17. INFORMANT <u>Mr. William Huston</u>		Address <u>Box 917</u> <u>Good Luck Rd. Lanham</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis, left temporal lobe</u> <u>332X</u> DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>MD.</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u>		22. DATE SIGNED <u>10-11-66</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		Address (Street, city, town, or county) <u>10-11-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 15, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial Park</u>	23d. LOCATION (City, town or county) (State) <u>Sheriff Rd. Landover Md.</u>
24. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO., Riverdale, Maryland</u>		25a. REC'D BY REGISTRAR <u>OCT 17 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11522

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14589 14590

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District Of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		d. STREET ADDRESS <u>5521 Colorado Avenue, N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chamber's Funeral Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Silas H Jacobs</u>				4. DATE OF DEATH <u>10 18 19 66</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>18 July 1872</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dispatcher-Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		9. AGE (In years last birthday) <u>94</u> yrs.		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Lucile J. Jacobs</u> Address <u>2 Park Lane Mt. Vernon, N.Y.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerotic heart disease</u> (b) <u>over 2 yrs.</u> (c) <u>over 2 yrs.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				22. DATE SIGNED <u>10-19-66</u>			
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>10/21/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>The S.H. Hines Company</u> <u>2901 14th St. N.W. Washington</u>				25a. REC'D BY REGISTRAR <u>OCT 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14590

CERTIFICATE OF DEATH

14591

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial		d. STREET ADDRESS 2904 Jamestown Road	
3. NAME OF DECEASED (Type or print) Helen		4. DATE OF DEATH Month October Day 12 Year 1966	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-22-75
9. AGE (in years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John William Fisher		14. MOTHER'S MAIDEN NAME Helen Elizabeth Hines	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 213-56-0549	
17. INFORMANT Margaret Rollman W Hyattsville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 2 yrs. 4500 DUE TO (b) Gen. Arteriosclerosis (duration unknown) DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obstructive Jaundice		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-30/10/14, 1964 , to 10-12, 1966 , that (I) (we) last saw the deceased alive on 10-12, 1966 , and that death occurred at 7:20AM , from causes and on the date stated above.			
22a. SIGNATURE C. J. Houmann		22b. DATE SIGNED 10-12-66	
22c. PHYSICIAN'S NAME (Type) C. J. Houmann, M. D.		22d. ADDRESS 4404 Queensbury Road, Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 14, 1966	23c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery	23d. LOCATION (City or Town) (County) (State) Sharpsburg Wash co Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR OCT 17 1966	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE f Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 3 should be filed with the State Dept. of Health within 72 hours after death.

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RECEIVED BY DEPT.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Item 23 Film G383 11/25/66 mh										
14591					14592					
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights			16-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital					d. STREET ADDRESS 904 64th St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Mary E Jefferson					4. DATE OF DEATH Month Day Year October 3 19 66					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 23, 1890		9. AGE (In years last birthday) 76 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private Home		11. BIRTHPLACE (County & State, or foreign country) Blackstone Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Mittie Taylor					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. —		17. INFORMANT Address J.W. Brown 5403 Addison Ch. Road.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Acidosis DUE TO 210X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Diabetes Mellitus DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis Cardiovascular System								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (s) (this hospital) attended the deceased from Sept. 18 , 19 66 , to October 3, 1966 , that (s) (we) last saw the deceased alive on October 3, 19 66 , and that death occurred at 6:30 AM , from causes on and on the date stated above.										
22a. SIGNATURE A. Clark Holmes					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/3/66			
22c. PHYSICIAN'S NAME (Type) A. Clark Holmes, M.D.					22d. ADDRESS 4108 Pratt St. Upper Marlboro, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/7/66		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION (City or Town) (County) (State) Suitland Rd., Suitland, Md.				
24. FUNERAL DIRECTOR H.S. Washington & Sons 4925 Denne Avenue					ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 7 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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James George

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14592 CERTIFICATE OF DEATH 14593											
1. PLACE OF DEATH a. COUNTY <u>PRINCE Geo</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>P-G</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Marlow Heights</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>P.G. Gen Hospital</u>						d. STREET ADDRESS				16-1	
3. NAME OF DECEASED (Type or print) <u>Robert L. Jenkins</u>						4. DATE OF DEATH <u>Oct 12</u>		Day		Year <u>1966</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1898</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Police</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Police Dept.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chas Co Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JAMES JENKINS</u>						14. MOTHER'S MAIDEN NAME <u>MARY E SWANN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>WWII 577-46-0605</u>		17. INFORMANT <u>Joseph Jenkins</u>			Address <u>Hughesville Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Coronary artery disease</u> DUE TO (c) <u>2 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>October</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>October 6</u> , 19 <u>66</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>J. Sanford Young</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/13/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. Sanford Young</u>						22d. ADDRESS <u>4400 Stamp Rd., Temple Hills, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 17, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT.</u>		23d. LOCATION (City, town or county) (State) <u>ARLINGTON VA.</u>					
24. FUNERAL DIRECTOR <u>Huntt Funeral Home</u>						ADDRESS <u>Waldorf Md</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Prince Geo

Mb

P.E.

D.O.A.

Chancery

P.G. Gen Hospital

Jenkins

Robert

M

M

Ret Police

CHAS CO MA U.S.A.

JAMES JENKINS

MARY E SWAN

WILL

JOSEPH JENKINS

Mb

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ARRINGTON NAT ARRINGTON VA

First General Store Building

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT

14593

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14594

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 40 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William H. Jenkins		4. DATE OF DEATH 10 21 1966	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 29 May 1907	
9. AGE (In years last birthday) 59		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Bldg.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Tilden Jenkins (deceased)		14. MOTHER'S MAIDEN NAME Laura Jane Frye (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Harriet Spilke, Laurel, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive interventricular hemorrhage 5810 DUE TO Cerebral Hemorrhage, Right internal capsule Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive vascular disease DUE TO Fatty nutritional cirrhosis (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 2 hrs. unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 10-21-66	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Type) Burial		23b. DATE THEREOF Oct. 24, 1966	
23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery, Laurel, Maryland		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland		25a. REC'D BY REGISTRAR DATE OCT 26 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

14553

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14553

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14594

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14595

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GLASS MANOR</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suitland Nursing Home</u>		d. STREET ADDRESS <u>407- GARDEN ST</u>	
3. NAME OF DECEASED (Type or print) <u>Gertrude A. Jochum</u>		4. DATE OF DEATH <u>10-16-1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/18/1892</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Oays Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Wheeling, West VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Fred Peters</u>		14. MOTHER'S MAIDEN NAME <u>MARY BOSS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Bertice Mellon</u> Address <u>20021 407 Garden St MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/25, 1966</u> , to <u>10/16, 1966</u> , that (I) (we) last saw the deceased alive on <u>10/16, 1966</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Max E. Feldman</u> M.O.		22b. DATE SIGNED <u>10/17/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. MAX FELDMAN</u>		22d. ADDRESS <u>3800 South Capitol ST.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 19-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 19 1966</u>	
25c. LICENSED D.C. & Md.			

14524

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14595

CERTIFICATE OF DEATH

14596

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Delores Middle Morina Last (Johnson)		4. DATE OF DEATH Month October Day 20 Year 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 28, 1931
9. AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Beatha Tolliver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Verd Matthews		Address 6305 Southern Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5810 DUE TO Hepatic failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cirrhosis of Liver (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pancreatitis, acute		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 4 (this hospital) attended the deceased from October 11, 19 66 , to October 20 19 66 that 4 (we) last saw the deceased alive on October 20 19 66 , and that death occurred at 6:30 P M, from causes and on the date stated above.			
22a. SIGNATURE Dr. Leelacer,		22b. DATE SIGNED 10-21-66	
22c. PHYSICIAN'S NAME (Type) Dr. Leelacer,		22d. ADDRESS Prince George's Genl. Hosp., Cheverly Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) 10-25-66		23b. DATE THEREOF 10-25-66	
23c. NAME OF CEMETERY OR CREMATORY Queens Chapel		23d. LOCATION (City or Town) (County) (State) Worthington Md	
24. FUNERAL DIRECTOR Washington		25a. REC'D BY REGISTRAR DATE OCT 26 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

14296

14292

EXHIBIT OF DEEDS

John George's

John George's

John George's

(Johnson)

John George's

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "John George's" and "(Johnson)" are visible.]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14596

14597

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>47-3</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			c. LENGTH OF STAY IN 1b <u>3 days</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hyattsville Nursing Home</u>			d. STREET ADDRESS <u>2901 Otis Street, N.E.</u>		
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>May</u> Last <u>Johnson</u>			4. DATE OF DEATH <u>OCTOBER 4 1966</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-13-87</u>	9. AGE (in years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u> Hours <u>66</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chicago, Illinois</u>	
13. FATHER'S NAME <u>Edgar Miller</u>			14. MOTHER'S MAIDEN NAME <u>Julie Huntington</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-01-3265-D</u>		17. INFORMANT <u>Mr. Albert L. Johnson</u> Address <u>5406-14th Ave., Hy., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral vascular insufficiency</u> DUE TO (c) <u>Severe generalized arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>several years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myelodysplastic Disorder</u> <u>Osteomyelitis - sternal</u>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>perfect</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Silver Spring Ave</u>	
20f. (City or town) (County) (State) <u>Silver Spring</u> <u>Maryland</u>		21. I certify that (this hospital) attended the deceased from <u>10/1/66</u> , 19 <u>66</u> , to <u>10/4</u> , 19 <u>66</u> , that (we) last saw the deceased alive on <u>10/4</u> , 19 <u>66</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold W. Draper</u>		22b. DATE SIGNED <u>10/4/66</u>		22c. PHYSICIAN'S NAME (Type) <u>HAROLD W. DRAPER M.D.</u>	
22d. ADDRESS <u>911 Silver Spring Ave</u>		22e. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>10/7/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Com.</u>	
23d. LOCATION (City, town or county) (State) <u>Colmar Manor, Md.</u>		23e. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		25. DATE <u>OCT 10 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14507

14526

COPIES

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14507-14508

575-01-2855-1 M. ALBERT J. JOHNSON
(201)

NO

Transmitted 10/1/65
General Home 100

North Lincoln Gen.
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oxon Hill, Maryland		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oxon Hill, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6223- Livingston Road SE		d. STREET ADDRESS 6223- Livingston Road SE	
3. NAME OF DECEASED (Type or print) THOMAS I. KEANE		4. DATE OF DEATH Month Oct. Day 15th Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17th 1905 61 yrs.
9. AGE (in years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 15 Days 19 Hours 66 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11b. KIND OF BUSINESS OR INDUSTRY US Gov.	
11. BIRTHPLACE (County & State, or foreign country) Pittsburgh, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas A. Keane		14. MOTHER'S MAIDEN NAME Ella Gray	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 15771	
17. INFORMANT Mrs. Ruth A. Keane (Wife) Same as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Emphysema DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March , 19 62 , to 10-15 , 19 66 , that (I) (we) last saw the deceased alive on 10-13 19 66 , and that death occurred at 6:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE E. Etienne Szollosi		22b. DATE SIGNED 10-15/66	
22c. PHYSICIAN'S NAME (Type) Etienne Szollosi, M.D.		22d. ADDRESS 2 Parkway Drive, Forest Hgts. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 18-1966	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Simmons Bros.		25a. REC'D BY REGISTRAR OCT 18 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. ADDRESS 1661- Gd. Hope Rd. SE. Wash., DC	

MEDICAL CERTIFICATION

14204

RECEIVED - 10-15-58

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14598
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
14599

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>				d. STREET ADDRESS <u>3501 Shepard Street</u>			
3. NAME OF DECEASED (Type or print) <u>Roberta Kelly Knight</u>				4. DATE OF DEATH <u>10 15 19 66</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>18 April 1942</u>	
9. AGE (In years last birthday) <u>24</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		9. AGE (In years last birthday) <u>24</u> yrs.	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Myrtle Kilby</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. (If yes give war or dates of service)			
17. INFORMANT <u>Louis R. Knight Same as #2 (husband)</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound of chest</u> 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in chest.</u>			
20c. TIME OF INJURY Month, Day, Year <u>6:00pm 10-15 19 66</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bedroom of home</u>				20f. (City or town) (County) (State) <u>same as #2</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22. DATE SIGNED <u>10-17-66</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/21/66</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>				23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>			
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>			
25a. REC'D BY REGISTRAR <u>OCT 24 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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[Handwritten signature]

10,214

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14599 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14600

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u>		d. STREET ADDRESS <u>1720 Saratoga St</u> 1920	
3. NAME OF DECEASED (Type or print) <u>EDWARD JOSEPH KULDA</u>		4. DATE OF DEATH <u>Oct 5</u> 19 <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 19 1952</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Dc</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Joseph Kulda Jr</u>		14. MOTHER'S MAIDEN NAME <u>Anna Bai Sexton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1920 1114 Saratoga St</u>	
17. INFORMANT <u>Edward Joseph Kulda, Jr.</u>		17. ADDRESS <u>Adelphi Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Wounds multiple +</u> 9100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Severe - surgical shock from wounds</u> DUE TO (c) <u>exsanguination</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Cherry of abandoned house fell on Subject</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:00 p.m. 10-5 1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Abandoned house</u>		20f. (City or town) <u>Adelphi</u> (County) <u>Pr Geo</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 10-5-66	
ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 5318 am...	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bladensburg Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 8, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) <u>Colmar Manor PA</u> (State) <u>Pa</u>	
24. FUNERAL DIRECTOR <u>Walter Waters</u> ADDRESS <u>254 Carroll St, Bk W Washington, D.C. 20012</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT-10 1966</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14600

CERTIFICATE OF DEATH

14601

| | | | | | | | |
|--|----------------------------------|---|--------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Pr. Geo. Co. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY P.G. Co. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly, Md. | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Suitland, Md. 16.1 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Pr. Geo. Gen. Hospital | | | | d. STREET ADDRESS
5076 Silver Hill Ct. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First John Middle T. Last Lacy
Lacey | | | | 4. DATE OF DEATH
Month October Day 10 Year 1966 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/31/1898 | | 9. AGE (In years last birthday) yrs.
68 | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Met. Club | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Harry Lacy | | | | 14. MOTHER'S MAIDEN NAME
Jennie Maguire | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
579-01 3833 | | 17. INFORMANT Address
Mrs Mae P. Lacy wife Same #2d | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
5271 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Pulmonary emphysema
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 day | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Arteriosclerotic heart disease | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from August 23, 1966 , to 10/11, 1966 , that (I) (we) last saw the deceased alive on 10/19, 1966 , and that death occurred at 2:40 P.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Henry J. Palacios | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
HENRY J. PALACIOS | | | | 22d. ADDRESS
6800 Indian Head Hwy Washington 20022 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/12/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt Olivet Cem. | | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. | |
| 24. FUNERAL DIRECTOR
Lee Funeral Home 300-4th St. N.E. | | | | 25a. REC'D BY REGISTRAR
OCT 13 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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14804

STATE OF DEATH

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

14601

14602

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
<u>PRINCE GEORGE</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>CHEVERLY</u>
c. LENGTH OF STAY IN 1b
<u>16.1</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>99 DCA Prince George Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
<u>Maryland</u>
b. COUNTY
<u>Prince George</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cheverly</u>
d. STREET ADDRESS
<u>2902 64th Ave.</u>
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
<u>FRANCES C. LEAKE</u> | | 4. DATE OF DEATH
Month <u>Oct.</u> Day <u>4</u> Year <u>1966</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Mar. 29, 1895</u> |
| 9. AGE (In years last birthday)
<u>71</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>FW</u> | 11. BIRTHPLACE (County & State, or foreign country)
<u>Baltimore, Md</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | | 13. FATHER'S NAME
<u>Joseph Funk</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Mary Logovity</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)
<u>No</u> | |
| 16. SOCIAL SECURITY NO.
<u>—</u> | | 17. INFORMANT
<u>Mrs. Patricia Windsor</u>
Address <u>6708 Stanton Rd Hy. Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Conjunctive Heart Failure</u>
<u>6000</u> DUE TO (b) <u>Arterio Sclerotic Heart Disease</u>
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (c) <u>Chronic Pyelo Cystitis.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
<u>5 hrs</u>
<u>Progressive</u>
<u>8 yrs</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour <u>19</u> a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 26, 1947</u> to <u>Oct. 4, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept. 27, 1964</u> , and that death occurred at <u>11:30 PM</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Leland E. Stevenson M.D.</u>
M.D. | | 22b. DATE SIGNED
<u>Oct 7, 1966</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Leland E. Stevenson</u> | | 22d. ADDRESS
<u>2101-R-St. N.W. - D.C. 20008</u> | |
| 23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>Oct 8, 1966</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Mary's</u> | | 23d. LOCATION (City, town or county) (State)
<u>Wash. D.C.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>FRANK GIER'S SONS Co.</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | |
| ADDRESS
<u>3605 14th St NW WASH DC</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

14802

14802

CERTIFICATE OF DEATH

I, the undersigned, being a duly qualified Medical Officer of Health for the City and County of New York, do hereby certify that on the 14th day of August, 1908, at New York City, died
 the within named person, who was born on the 14th day of August, 1874, at New York City, and was at the time of death a resident of New York City, and was a native-born American citizen.

Cause of Death: Chronic Papal Cancer.
 Duration of Illness: 3 weeks.
 Signature: [Signature]

Date: 14th day of August, 1908.
 Place: New York City.

Signed and attested at New York City, New York, this 14th day of August, 1908.
 Leland E. Stevenson, M.D.
 Health Officer

2101-R-24-W.-D.C. 20008

1
M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14602

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14603

| | | | |
|---|-----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant | |
| c. LENGTH OF STAY IN 1b DOA | | d. STREET ADDRESS 7243 Hilton Street | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Alfonzo Middle Linwood Last Leath | | 4. DATE OF DEATH
Month 10 Day 23 Year 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 26 Feb. 1935 |
| 9. AGE (In years last birthday) 31 yrs. | | 10. IF UNDER 1 YEAR
Months 10 Days 23 Hours 19 Min. 66 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY North Carolina | |
| 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charlie Leath | | 14. MOTHER'S MAIDEN NAME Ardelia Neal | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Clara Satterfield-912 Shepherd N.W. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Left hemothorax, 1000cc.
8164
DUE TO Multiple puncture wounds of left lung
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) from multiple rib fractures
DUE TO From trauma- auto accident
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Driver of car involved in collision. | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 4:10am 10-23- 1966 | | 20d. INJURY OCCURRED <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Prince George Co., Md. (City or town) (County) (State) | | 20f. Baltimore Washington Parkway near Rt. 50. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | 22. DATE SIGNED 10-24-66 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE THEREOF 10-24-66 | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) BURLINGTON, N.C. |
| 24. FUNERAL DIRECTOR FRAZIER'S FUNERAL Home-WASH, D.C. | | 25a. REC'D BY REGISTRAR OCT 25 1966 25b. REGISTRAR'S SIGNATURE Charles Judge | |

14003

14003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14603

CERTIFICATE OF DEATH

14604

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
PRINCE GEORGE'S
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ANDREWS AIR FORCE BASE
c. LENGTH OF STAY IN 1b
205 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
USAF HOSPITAL ANDREWS | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
PRINCE GEORGE'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SUITLAND
d. STREET ADDRESS
7817 PENN AVE EXT
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
WILLIAM EVERETT LE SUEUR | | | | 4. DATE OF DEATH
Month Day Year
OCTOBER 29 19 66 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
CAUCASIAN | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
21 OCT 1931 | |
| 9. AGE (In years lost birthday)
35 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
COUNTER PARTS MAN | | 10b. KIND OF BUSINESS OR INDUSTRY
AUTOMOTIVE | | 11. BIRTHPLACE (County & State, or foreign country)
MASSACHUSETTS | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
EVERETT LE SUEUR | | | |
| 14. MOTHER'S MAIDEN NAME
EFFIE CLOUTER | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
YES 1951-1955 | | | |
| 16. SOCIAL SECURITY NO.
015-24-5494 | | | | 17. INFORMANT
HARRIETTE LE SUEUR-WIFE-SAME AS #2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY FAILURE
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) HODGKINS DISEASE
DUE TO
(c) UNKNOWN | | | | INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7 APR , 19 66 , to 29 OCT , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 29 OCT , 19 66 , and that death occurred at 1:15M , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>John D. Hallenwell</i> | | | | 22b. DATE SIGNED
29 OCT 66 | | 22c. PHYSICIAN'S NAME (Type)
DR. A. GOULD, CAPT, USAF, MC | |
| 22d. ADDRESS
USAF HOSPITAL ANDREWS | | | | 22e. ADDRESS
ANDREWS AFB, WASHINGTON DC 20331 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Nov. 1st 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia | |
| 24. FUNERAL DIRECTOR
<i>Simmons Bros.</i> | | | | 25a. REC'D BY REGISTRAR
DATE NOV 1 1966 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

14802

14802

HARVARD

COTLAND

1817 PARK AVENUE

2 SUITE

WILLIAM

WILLIAM

11 COE ST

AMERICAN

SALE

RESEARCH UNIT

RESEARCH UNIT

RESEARCH UNIT

RESEARCH UNIT

RESEARCH UNIT

RESEARCH UNIT

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14604

CERTIFICATE OF DEATH

14605

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 1 hr. 15 min. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
Paul E. Luttner | | 4. DATE OF DEATH Month Day Year
Oct. 30 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-7-23 |
| 9. AGE (In years last birthday) 42 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (County & State, or foreign country) Latrobe, Penna. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Luttner | | 14. MOTHER'S MAIDEN NAME Mary Stiener | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII | | 16. SOCIAL SECURITY NO. 191-12-8679 | |
| 17. INFORMANT Mrs. Margaret H. Luttner (above) | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 Myocardial infarction
DUE TO (b) Arteriosclerotic Cardiovascular Disease
DUE TO (c) 7 mo | | INTERVAL BETWEEN ONSET AND DEATH 4 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from JUNE 1961 to 10-30, 19-66 that (1) (we) last saw the deceased alive on 10-30-66 and that death occurred at 10-15A M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE William D. Rosson MD | | 22b. DATE SIGNED 10/30/66 | |
| 22c. PHYSICIAN'S NAME (Type) William D. Rosson | | 22d. ADDRESS 5701 85th AVE HYATTSVILLE MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 11/2/66 | 23c. NAME OF CEMETERY OR CREMATORY Arl. Nat. Cem. | 23d. LOCATION (City or Town) (County) (State) Arlington, Va. |
| 24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. | | 25a. REC'D BY REGISTRAR DATE NOV 4 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4062 Y

2075-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed from the certificate. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 2 Film c381 10/20/66 mh

CERTIFICATE OF DEATH

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lanham, Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>4007 1/2 Hyattsville, Md.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Magnolia Gardens Nursing Home</u> | | d. STREET ADDRESS <u>Tafton</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>James</u> Middle <u>Oscar</u> Last <u>LYNN</u> | | 4. DATE OF DEATH
Month <u>Oct</u> Day <u>11</u> Year <u>1966</u> | |
| 5. SEX <u>Male</u> | COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 9, 1880</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Meat Butcher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Meat Packing Co.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>MICHAEL J. LYNN</u> | | 14. MOTHER'S MAIDEN NAME
<u>Margaret HELEY</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>4539 Kirby Parkway</u> | |
| 17. INFORMANT
<u>Joseph Lynn</u> | | Address
<u>Oxen Hill, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>334X</u> DUE TO <u>General inanition</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u>
(c) <u>Generalized arteriosclerosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 months</u>
<u>3 years</u>
<u>5 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>CONTRIBUTING TO DEATH</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 1964</u> to <u>11 Oct 1966</u> that (I) was <u>saw</u> the deceased alive on <u>11 Oct 1966</u> , and that death occurred at <u>6:30</u> AM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Thomas G. Maloney</u> M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED
<u>11 Oct 66</u> |
| 22c. PHYSICIAN'S NAME (Type)
<u>THOMAS G. MALONEY</u> | | 22d. ADDRESS
<u>4814 71st AVE. WOODLAWN</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>10/14/66</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Queen of Peace</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Hawley Wayne Co. Pa.</u> |
| 24. FUNERAL DIRECTOR
<u>FRANCIS Gaschi's SON'S</u> | | ADDRESS
<u>Hyattsville, Md.</u> | 25a. REC'D BY REGISTRAR
<u>DATE OCT 13 1966</u> |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

1-1600

UNITED STATES DEPARTMENT OF AGRICULTURE

1-1600

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
1916

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14606

CERTIFICATE OF DEATH

14607

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Glenn Dale (rural) | | c. LENGTH OF STAY IN 1b
1 mo 22 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington, D. C. |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Glenn Dale Hospital | | d. STREET ADDRESS
1240 Lawrence St., N.E. | |
| 3. NAME OF DECEASED (Type or print)
First Leonard Middle Mack Last | | 4. DATE OF DEATH
Month 10/24/ Day 1966 | |
| 5. SEX
M | 6. COLOR OR RACE
N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
9/4/1898 |
| 9. AGE (In years last birthday)
68 yrs. | | 10. IF UNDER 1 YEAR
Months 4 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retired | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
S.C. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Robert Mack | | 14. MOTHER'S MAIDEN NAME
Lulu McDowell | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
094-03-4484 | |
| 17. INFORMANT
decedent | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage and bilateral bronchopneumonia
DUE TO (b) Carcinoma of the liver with metastases
DUE TO (c) Cirrhosis of the liver
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
4 days
unknown
1 year |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Porto-caval anastomosis, 4/66 | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that he (this hospital) attended the deceased from 9/2/ , 19 66 , to 10/24/1966 , that he (we) last saw the deceased alive on 10/24/ 19 66 , and that death occurred at 5:00PM from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Moe Weiss</i> | | 22b. DATE SIGNED
10/24/66 | |
| 22c. PHYSICIAN'S NAME (Type)
Moe Weiss, M.D. | | 22d. ADDRESS
Glenn Dale Hospital, Glenn Dale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Oct-27-1966 | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Memorial Cemetery | 23d. LOCATION (City or Town) (County) (State)
Suitland Maryland |
| 24. FUNERAL DIRECTOR
John T. Rhames | | 25a. REC'D BY REGISTRAR
DATE OCT 28 1966 | |
| ADDRESS
3015-12th St. N.E. DC | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14808

14808

14808

Prince George

Glenn Dale (Army)

Glenn Dale Hospital

Glenn Dale

Glenn Dale

10/24/40

1940

10/24/40

10/24/40

10/24/40

10/24/40

10/24/40

10/24/40

10/24/40

10/24/40

10/24/40

10/24/40

Gastrointestinal hemorrhage and ulceration
of the liver and spleen

Gastrointestinal hemorrhage and ulceration
of the liver and spleen

Gastrointestinal hemorrhage and ulceration
of the liver and spleen

Porto-caval anastomosis, 1940

10/24/40

10/24/40

10/24/40

10/24/40

Glenn Dale Hospital, Glenn Dale, Md.

Glenn Dale, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of this certificate may be retained by the hospital or attending physician. Page 1 of this certificate should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14607

14608

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|----------------------------------|--|---|--|--|--|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>41 A St</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Prince George</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> <u>16.1</u>
d. STREET ADDRESS <u>41 A St</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Charles Wm. Madision</u> | | 4. DATE OF DEATH Month <u>Oct</u> Day <u>3</u> Year <u>1966</u> | | 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct 15, 1886</u> <u>79</u> yrs. | | 9. AGE (In years last birthday) <u>79</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>head of maintenance town of Laurel Wash. D. C.</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | |
| 13. FATHER'S NAME <u>James Austin Madision</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Annie Goddard</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT <u>Robert Madision</u> Address <u>Laurel Md</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] | | | | | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) <u>331X</u> DUE TO <u>C.V.A.</u>
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Generalized arteriosclerosis,</u> | | | | | | | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e). | | | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> to <u>10-3-1966</u> , that (I) (we) last saw the deceased alive on <u>10-1-1966</u> , and that death occurred at <u>11:25 A.M.</u> from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Idolo Pierandrei</u> M.D. | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>IDOLO PIERANDREI</u> | | | | | | | | 22d. ADDRESS <u>Laurel Md</u> | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>10-6-66</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Hill Cem</u> | | | | 23d. LOCATION (City, town or county) (State) <u>Laurel Md.</u> | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Donaldson</u> Address <u>Laurel Md</u> | | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |
| DATE <u>OCT 13 1966</u> | | | | | | | | | | | | | | | | | | | | | | | |

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C.V.A.
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Edith P. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George C.</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Hyattsville</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Hyattsville</u> | | | 16.1 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Hyattsville Nursing Home</u> | | | | | d. STREET ADDRESS
<u>5700-31st Place</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Bedelie Margaret C. Manning</u> | | | | | 4. DATE OF DEATH
Month Day Year
<u>Oct. 30, 1966</u> 19 | | | | | |
| 5. SEX
<u>F</u> | | 6. COLOR OR RACE
<u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
<u>10-30-1898</u> | | 9. AGE (in years last birthday)
<u>67</u> yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>none</u> | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Lawrence Lazarus Costello</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Julia Ann Cooney</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
<u>JAMES MANNING 105-6th St., S.E. - HUSBAND</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Baile's artery syndrome</u>
<u>334X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u>
DUE TO (c) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/1/64</u> , 19 <u>64</u> , to <u>Present</u> , 19 <u>66</u> , that <u>we</u> last saw the deceased alive on <u>10/24/1966</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE
<u>George L. Stewart</u> | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>10-29-66</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>George L. Stewart</u> | | | | | 22d. ADDRESS
<u>2390 Glenmont Circle, Wheaton, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>11/2/1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Ft. Lincoln Cem</u> | | 23d. LOCATION (City, town or county) (State)
<u>Bladensburg, Md.</u> | | | | |
| 24. FUNERAL DIRECTOR
<u>Jas. T. Ryan, Inc.</u> | | | | | ADDRESS
<u>317 Pa. Ave., SE WashDC</u> | | 25a. REC'D BY REGISTRAR
<u>NOV 2 1966</u> | | 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | |

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U.S. T. Ryan, Inc., 1155 Ave. of the Americas, New York 10036
Nov 1, 1966

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14609

14610

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|----------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY IN lb
12 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville
d. STREET ADDRESS
4808 69th Place
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Charles P. Marcellino | | 4. DATE OF DEATH
Month Oct. Day 8 Year 19 66 | |
| 5. SEX
Male | 6. COLOR OR RACE
Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-26-07 |
| 9. AGE (In years last birthday)
58 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Self Employed | | 10b. KIND OF BUSINESS OR SERVICE
Shoe Repairer | |
| 11. BIRTHPLACE (County & State, or foreign country)
Washington D.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Vincent Marcellino | | 14. MOTHER'S MAIDEN NAME
Salvatine Scaletta | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Leona E. Marcellino (above add-ress) | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
(IMMEDIATE CAUSE (a) Shock
5400 DUE TO G.I. bleeding
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Peptic ulcer
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 9-26 , 19 66 , to 10-8 , 19 66 , that (I) (we) last saw the deceased alive on 10-8 , 19 66 , and that death occurred at 2:25A , M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
A. Clark Holmes | | 22b. DATE SIGNED
10/8/66 | |
| 22c. PHYSICIAN'S NAME (Type)
A. Clark Holmes, M.D. | | 22d. ADDRESS
4108 Pratt St., Upper Marlboro, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/11/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cem. | | 23d. LOCATION (City or Town) (County) (State)
Golmar Manor, Md. | |
| 24. FUNERAL DIRECTOR
Nalley's Funeral Home Inc. | | 25. REC'D BY REGISTRAR
DATE OCT 13 1966 | |
| ADDRESS Mt. Rainier, Maryland | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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RECORDS OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14610 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14611

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | |
| c. LENGTH OF STAY IN 1b 1 hr. 35 Min. | | d. STREET ADDRESS 6904 Vallery Street | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Regina | | 4. DATE OF DEATH 10 12 1966 | |
| 5. SEX Female | | 8. DATE OF BIRTH 8 Oct. 1966 | |
| 6. COLOR OR RACE White | | 9. AGE (In years last birthday) yrs. 4 | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Albert Frank Marks | | 14. MOTHER'S MAIDEN NAME Mary Theresa Hooven | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Mr. Albert F. Marks (above address) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 7680 Right cerebral necrosis
DUE TO Infection by Proteus Vulgaris
(b) From septicemia
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | 22. DATE SIGNED 10-13-66 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10/17/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Com. | | 23d. LOCATION (City, town or county) (State) Arlington, Va. | |
| 24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. | | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE j Charles Judge | |
| ADDRESS Mt. Rainier, Maryland | | DATE OCT 20 1966 | |

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ATLANTA, GEORGIA

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14611

14612

| | | | | | | | |
|---|---------------------------|---|--------------------|--|-----------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>P. G.</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>404 Marshall Ct Apt F</u> | | | | d. STREET ADDRESS <u>404 Marshall Ct</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Edna Ruth</u> | | First Middle Last | | 4. DATE OF DEATH | | Month Day Year | |
| | | | | <u>Oct 4</u> | | <u>1966</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <u>May 10 1905</u> | <u>61</u> yrs. | Months Days | Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>same</u> | | 11. BIRTHPLACE (State or foreign country) <u>Broad Creek Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Edward Mc Ney</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary M. Young</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>no</u> | |
| 17. INFORMANT <u>Amy M. Berger</u> | | Address <u>160 Prospect St Orange, N.J.</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bilateral pulmonary edema, Severe</u>
410X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) <u>Mitral Stenosis - Rheumatic Valvulitis</u>
DUE TO (c) <u>years</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Dayton Watkins</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>DAYTON WATKINS</u> | | Address (Street, city, town, or county) <u>Beardsbury rd</u> | | 22. DATE SIGNED <u>10-4-66</u> | | 23. DATE SIGNED <u>2318</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>10-7-66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem</u> | | 23d. LOCATION (City, town or county) (State) <u>Wheaton Md</u> | |
| 24. FUNERAL DIRECTOR <u>De Witt Donaldson</u> | | Address <u>Laurel Md</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>OCT 13 1966</u> | | | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1901

1901

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14612

14613

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE
Md. b. COUNTY
Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
William Franklin McLean | | | | 4. DATE OF DEATH
Month Day Year
10 15 19 66 | | | |
| 5. SEX
M | | 6. COLOR OR RACE
W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
Feb., 13, 1899 | |
| 9. AGE (In years last birthday)
67 yrs. | | 10. KIND OF BUSINESS OR INDUSTRY
Electrical inspector | | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
William F. Mc Lean | | | | 14. MOTHER'S MAIDEN NAME
Louisa Pry | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
yes | | 16. SOCIAL SECURITY NO.
WW 1 184 12 8053 | | 17. INFORMANT
Walter E Mc Lean | | | |
| | | | | Address
Arlington Virginia | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
4200 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Minutes
Over 2 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes Mellitus-over 5 yrs. | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) | | John Kehoe, M.D., Riverdale | | | | 22. DATE SIGNED
1-16-66 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/19/66 | | 23c. NAME OF CEMETERY OR CREMATORY
G A R Cemetery | | 23d. LOCATION (City, town or county) (State)
Summit Hill Pa. | |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons | | | | ADDRESS
Hyattsville, Md. | | 25a. REC'D BY REGISTRAR
DATE OCT 19 1966 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE
OF NEW YORK

1918

IN SENATE
JANUARY 1, 1918

1918

REPORT OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
JANUARY 1, 1918

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS
1918

1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G381 10/11/66 mh

14613

CERTIFICATE OF DEATH

14614

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Charles | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
18 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Bertha Middle B Last Mercilllott | | 4. DATE OF DEATH
Month October Day 3 Year 1966 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/19/72 1882 |
| 9. AGE (In years last birthday)
84 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Penna. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Andrew Jackson | | 14. MOTHER'S MAIDEN NAME
Nella Steele | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Warren P. Mercilllott 4001 Warner Ave. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest
DUE TO CUA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. myocardial infarction
DUE TO (b) hypertension
DUE TO (c) arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
2 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 1966 to Oct 1966 , that (I) (we) last saw the deceased alive on 10/2 1966 , and that death occurred at 5:20 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Leon R. Levitsky, M.D. | | 22b. DATE SIGNED
10-3-66 | |
| 22c. PHYSICIAN'S NAME (Type)
Leon R. Levitsky, M.D. | | 22d. ADDRESS
3408 Rhode Island Ave., Mt. Rainier, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
10/6/66 | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | 23d. LOCATION (City or Town) (County) (State)
Prince Georges, Md. |
| 24. FUNERAL DIRECTOR
Wilhelm Funeral Home | | 25a. REC'D BY REGISTRAR
OCT 5 1966 | |
| ADDRESS
4308 Suitland Rd. Suitland Md. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

11011

STATE OF TEXAS

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County of

County of

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14614

CERTIFICATE OF DEATH

14615

| | | | | | | | |
|---|----------------------------------|---|-------------------------------------|--|---|--|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
2 hrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Glen Ridge (Hyattsville P.O.) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | | | d. STREET ADDRESS
7107 Decatur St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Margaret Middle P. Last Midgley | | | | 4. DATE OF DEATH
Month October Day 22 , Year 1966 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/17/09 | 9. AGE (In years last birthday) yrs.
57 | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bookkeeper | | 10b. KIND OF BUSINESS OR INDUSTRY
Union Trust Co. | | 11. BIRTHPLACE (County & State, or foreign country)
New York | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Joseph Tartone | | | | 14. MOTHER'S MAIDEN NAME
Josephine Labriola | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
086 12 6947 | | 17. INFORMANT
Richard Peter Midgley Same as #2 (son) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular Fibrillation
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myocardial Infarction
DUE TO (c) Arteriosclerotic Heart Disease
INTERVAL BETWEEN ONSET AND DEATH
4 1/2 hrs.
7 1/2 hrs.
1 yr. | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from October , 19 65 , to Oct. 22 , 19 66 , that (I) (we) last saw the deceased alive on October 22 , 19 66 , and that death occurred at 1:15 M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Thomas G. Maloney M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
22 Oct 66 | |
| 22c. PHYSICIAN'S NAME (Type)
Thomas G. Maloney, M. D. | | | | 22d. ADDRESS
4814 71st Ave., Landover Hills, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/25/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City or Town) (County) (State)
Arlington Va. | |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons Hyattsville, Md | | | | 25a. REC'D BY REGISTRAR
OCT 26 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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OFFICE OF THE ATTORNEY GENERAL

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14615 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14615

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | |
| c. LENGTH OF STAY IN 1b 10 years | | d. STREET ADDRESS 5617 Kennedy St | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5617 Kennedy Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) SAMUEL WILLIAM E. MILLS | | 4. DATE OF DEATH Oct 4 1966 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4 OCT 1908 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | 11. BIRTHPLACE (State or foreign country) Rockingham Va | |
| 10b. KIND OF BUSINESS OR INDUSTRY Rail Road | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME David William Mills | | 14. MOTHER'S MAIDEN NAME ADA KNUPP | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 378-07-0666 | |
| 17. INFORMANT David Mills | | Address Riverdale Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Contusions
976X DUE TO Lacerations
(b) Lacerations
(c) Gun shot wound
underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH instant |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gun shot wound of head | |
| 20c. TIME OF INJURY Month, Day, Year Oct 4 1966 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | 20f. (City or town) Riverdale (County) Prince George (State) Md |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Dayton O Watkins | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) DAYTON O WATKINS | | 22. DATE SIGNED 10-4-66 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 7 OCT. 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM | | 23d. LOCATION (City, town or county) BLADENSBURG (State) MD | |
| 24. FUNERAL DIRECTOR W. W. Chambers Co. | | ADDRESS RIVERDALE, MD | |
| 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE f Charles Judge | |

14016

14016

14016



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2d Film G382 11/15/66 mh

FOR STATE
HEALTH DEPT.

14616

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14617

| | | | | | | | |
|--|----------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN lb
DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bradbury Heights | | 16.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George General Hospital | | | | d. STREET ADDRESS
4803 W. 14th Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Leon Woodrow Myers | | | | 4. DATE OF DEATH
Month Day Year
10 30 19 66 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
29 March 1913 | | 9. AGE (In years last birthday)
53 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Checker | | 10b. KIND OF BUSINESS OR INDUSTRY
D. & S. Warehouse | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
EDWARD MYERS | | | | 14. MOTHER'S MAIDEN NAME
ELLA HATFIELD | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
579073896 | | 17. INFORMANT
SUSIE C. MYERS | | Address
SAME AS #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
4200 DUE TO Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
minutes
unknown | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
John Kehoe | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | Address (Street, city, town, or county)
10-31-66 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2 Nov 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
FT. LINCOLN | | 23d. LOCATION (City or Town) (County) (State)
BLADENSBURG, MARYLAND. | |
| 24. FUNERAL DIRECTOR
W.W. Chambers Co. Riverdale, Md. | | | | 25a. REC'D BY REGISTRAR
DATE NOV 5 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14811

UNITED STATES DEPARTMENT OF AGRICULTURE

1901

OFFICE OF THE SECRETARY

WASHINGTON

DEPARTMENT OF AGRICULTURE

WASHINGTON

DEPARTMENT OF AGRICULTURE

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DEPARTMENT OF AGRICULTURE

WASHINGTON

1 (M)
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14617

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14618

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Prince George's</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Park</u> | | | |
| c. LENGTH OF STAY IN 1b <u>DOA</u> | | | | d. STREET ADDRESS <u>407 65th. Street</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>Julia Ann Newman</u> | | | | 4. DATE OF DEATH Month Day Year
<u>10 25 19 66</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Negro</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>25 Feb. 1888</u> | |
| 9. AGE (In years lost birthday) yrs. <u>78</u> | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>---</u> | | 11. BIRTHPLACE (State or foreign country) <u>Prince George Co., MD.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>George Harley</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Georgianna Newman</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>John A. Newman</u> Address <u>407-65th St., Maryland Pk., Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Heart failure</u>
<u>4200</u> DUE TO <u>Arteriosclerotic heart disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>unknown</u>
(c) <u>unknown</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>unknown</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>John Kehoe</u> M.D. | | | | 22. DATE SIGNED <u>10-26-66</u> | | | |
| EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u> | | | | Address (Street, city, town, or county) <u>Riverdale, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>10/29/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Upper Marlboro, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Hollins, Inc</u> ADDRESS <u>4339 Hunt Pl., N.E.</u> | | | | 25a. REC'D BY REGISTRAR <u>OCT 28 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14618

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14619

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville | |
| c. LENGTH OF STAY IN lb DOA | | d. STREET ADDRESS 13205 Engleside Drive | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Walter Middle J. Last Nickle | | 4. DATE OF DEATH
Month 10 Day 20 Year 1966 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-21-1922 |
| 9. AGE (In years lost birthday) 44 yrs. | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cartographer | | 10b. KIND OF BUSINESS OR INDUSTRY U S Government | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Lester B Nickle | | 14. MOTHER'S MAIDEN NAME Emma Klaingler | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW II | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Rosalia D Nickle | | Address Beltsville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
4200 DUE TO Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH minutes
unknown |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | 22. DATE SIGNED 10-21-66 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Oct 25, 1966 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | 23d. LOCATION (City or Town) (County) (State) Arlington Va. |
| 24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. | | 25a. REC'D BY REGISTRAR OCT 26 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE J Charles Judge | |

19618

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film#G381 10/7/66 pc

CERTIFICATE OF DEATH

Jordan Oldham

14619

14620

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
22 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
College Park | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | | | d. STREET ADDRESS
9017 51st Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Jasper Middle G. Last Oldham | | | | 4. DATE OF DEATH
Month October Day 1 Year 19 66 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
4/3/07 | |
| 9. AGE (In years last birthday)
59 yrs. | | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> | | IF UNDER 24 HRS.
Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY
Greenbelt Town | | 11. BIRTHPLACE (County & State, or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Thomas T Oldham | | | | 14. MOTHER'S MAIDEN NAME
Florence Oveman | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
217 09 6183 | | 17. INFORMANT
Address
Lillian P Oldham College Park, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 163X Bronchopneumonia
DUE TO Cerebrovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) DUE TO
(c) DUE TO | | | | | | INTERVAL BETWEEN ONSET AND DEATH
7 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan , 19 65 , to Oct 1 , 19 66 ; that (I) (we) last saw the deceased alive on Sept 30 , 19 66 , and that death occurred on 9:15 M , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
George William Ware M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
10/1/66 | |
| 22c. PHYSICIAN'S NAME (Type)
George William Ware, M.D. | | | | 22d. ADDRESS
1835 Eye St., N.W., Washington, D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Oct 4, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor Pro Geo Md. | |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR
DATE OCT 4 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14620

14621

| | | | | | | | |
|--|---|--|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>
c. LENGTH OF STAY IN 1b <u>2 years</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Manor</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Washington, D.C.</u>
b. COUNTY <u>District of Columbia</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47-3</u>
d. STREET ADDRESS <u>2852 Ontario Rd., N.W.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Loretta H. H. O'Reilly</u>
First Middle Last | | | 4. DATE OF DEATH <u>Oct. 21 1966</u>
Month Day Year | | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 16, 1881</u> | | 9. AGE (In years last birthday) <u>84 yrs.</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered nurse</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Catham, Ontario, Canada</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13. FATHER'S NAME <u>Michael Doyle</u> | | | | |
| 14. MOTHER'S MAIDEN NAME <u>Catherine Dillow</u> | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | |
| 16. SOCIAL SECURITY NO. <u>612 715</u> | | 17. INFORMANT <u>Sr. M. Luke, O.Carm. Hyattsville, Md.</u> Address <u>4922 2nd St. N.W.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular Hemorrhage</u>
<u>443X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Hypertensive heart disease</u> DUE TO
(c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u>
<u>2 years</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ | 21. I certify that (I) (this hospital) attended the deceased from <u>June 5, 1966</u> to <u>Oct 21, 1966</u> that (I) (we) last saw the deceased alive on <u>Oct 20, 1966</u>, and that death occurred at <u>7:30 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Thomas F. Collins</u> | | 22b. DATE SIGNED <u>10-21-66</u> | | 22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. COLLINS</u> | | | |
| 22d. ADDRESS <u>364 "H" St NE</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u> | | | | | |
| 23b. DATE THEREOF <u>Oct 25, 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u> | | 23d. LOCATION (City or Town) <u>Pittsburg, Pennsylvania</u> (County) _____ (State) _____ | | | |
| 24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u> | | 25a. REC'D BY REGISTRAR <u>OCT 25 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12 1 M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 1 Film G381 10/17/66 mh

Item 2 Film G381 10/18/66 mh

14621

CERTIFICATE OF DEATH

14622

| | | | |
|---|------------------------|--|-------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN lb 8 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham Seat Pleasant 16.1 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | d. STREET ADDRESS 700 - 65th Ave. 9104 Good Luck Rd. | |
| 3. NAME OF DECEASED (Type or print) First Eliza Middle P Last Pace | | 4. DATE OF DEATH Month October Day 8, Year 19 66 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 4/24/92 1894 |
| 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY at home | |
| 11. BIRTHPLACE (County & State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Monie Jones | | 14. MOTHER'S MAIDEN NAME Maggie Herdon | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs Elsie Young Daughter) Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 332X Back obo pneumonia
DUE TO (b) Cerebral Thrombosis
DUE TO (c) Generalized Arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Diabetes Mellitus | | INTERVAL BETWEEN ONSET AND DEATH 2 days 11 days 2 yrs | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June, 1966, to Oct. 8, 1966, that (I) (we) last saw the deceased alive on Oct. 8, 66 19, and that death occurred at 1:05 PM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Norman L. Comeran M.D. | | 22b. DATE SIGNED 10/5/66 | |
| 22c. PHYSICIAN'S NAME (Type) Norman L. Comeran | | 22d. ADDRESS 3503 Penny St N | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10.11.66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION (City or Town) Suitland (County) (State) | |
| 24. FUNERAL DIRECTOR Lee Funeral Home | | 25a. REC'D BY REGISTRAR DATE OCT 11 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

VR A15 (4)
20 M 1/66

SS041

1522

OK by Dr John Mehoe m.d.
coroner 7:30am

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14622 CERTIFICATE OF DEATH 14623

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Riverdale | | c. LENGTH OF STAY IN 1b
D. O. A. | |
| c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
College Park | | d. STREET ADDRESS
4504 Beechwood Road | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Leland Memorial Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) MARION W. PARKER | | 4. DATE OF DEATH
Month 10 - Day 8 - Year 1966 | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Dec. 4, 1907 | |
| 9. AGE (In years last birthday)
58 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Adm. Agr. Res. | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Government | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John C. Parker | | 14. MOTHER'S MAIDEN NAME
Verta Parsons | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO.
217 44 0414 | |
| 17. INFORMANT
Mrs. Katherine H. Parker Same as #2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
4201 DUE TO (b) CORONARY THROMBOSIS ACUTE
DUE TO (c) CHRONIC CORONARY INSUFFICIENCY
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
1 hr
1 hr
2 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 1964, to 10/8, 1966, that (I) (we) last saw the deceased alive on 10-8 1966, and that death occurred at 5:30 M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Norman J. Comman | | 22b. DATE SIGNED
10/8/66 | |
| 22c. PHYSICIAN'S NAME (Type)
Norman J. Comman | | 22d. ADDRESS
3503 Pennysst Mt Rainier md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/11/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Parson's | | 23d. LOCATION (City, town or county) (State)
Salisbury Md. | |
| 24. FUNERAL DIRECTOR
Francis Gasch; Sons Hyattsville, Md. | | 25a. REC'D BY REGISTRAR
OCT 11 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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1. The following are the names of the persons who have been appointed to the various positions in the organization of the American Society of International Law:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14623

14624

| | | | | | | | |
|---|--|---|-------------------------------------|---|---------------------------|---|-------|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>md.</u> b. COUNTY <u>Prince Geo.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Riverdale Md.</u> | | c. LENGTH OF STAY IN lb
<u>9 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>College Pk, Md.</u> | | 16-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Eugene Land Memorial 4408 Queensbury Rd.</u> | | | | d. STREET ADDRESS
<u>4711 Tecumseh St</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>GLARYS</u> Middle <u>READ.</u> Last <u>PATRICK</u> | | | | 4. DATE OF DEATH
Month <u>10</u> Day <u>23</u> Year <u>1966</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11-12-02</u> | 9. AGE (In years last birthday)
<u>63</u> yrs. | IF UNDER 1 YEAR
Months | IF UNDER 24 HRS.
Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Statistical Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>National Security</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>md.</u> | | 12. CITIZEN OF WHAT COUNTRY
<u>U. S.</u> | |
| 13. FATHER'S NAME
<u>WILLIAM READ</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>MARGARET CISELL</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>579 05 4121</u> | | 17. INFORMANT
<u>Record Office 4408 Queensbury Rd. Riverdale, Md</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201 Acute Myocardial Failure</u>
DUE TO <u>Myocardial Infarction complicated by Ventricular Fibrillation</u>
DUE TO <u>after a severe coronary heart dis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>40 min</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a.m. _____
p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/15</u> , 19 <u>66</u> to <u>10/23</u> , 19 <u>66</u> , that (I) (we) lost <u>saw the deceased alive on 10/23</u> , 19 <u>66</u> , and that death occurred at <u>10:20</u> M. from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>W. L. Effienne</u> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>10-23-66</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>W. L. EFFIENNE</u> | | 22d. ADDRESS
<u>College Park Md</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>10-27-66</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>ARLINGTON NATIONAL</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>ARLINGTON, VIRGINIA.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>W. W. Chambers Co, Riverdale, Md.</u> | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE <u>OCT 26 1966</u> | | 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | |

15241

6528

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

14624

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14625

| | | | |
|--|--------------------|--|-------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital | | d. STREET ADDRESS 3338 Chauncy Place | |
| 3. NAME OF DECEASED (Type or print) First Richard Middle Wayne Last Patrick | | 4. DATE OF DEATH Month 10 Day 8 Year 19 66 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4 April 1949 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 11. BIRTHPLACE (State or foreign country) West Virginia | |
| 13. FATHER'S NAME Creed W Patrick | | 14. MOTHER'S MAIDEN NAME Marie V. Akers | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Creed W. Patrick | | Address Mt Rainier, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 8214 Left subdural hematoma
DUE TO (b) Right and left intra cerebral hemorrhages
DUE TO (c) Basilar skull fracture
Trauma-motorcycle accident | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Thrown from motorcycle | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 3:30 pm. 10 6 19 66 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6600 Block Belcrest Rd. | | 20f. (City or town) Prince George, Md. (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe | | 22. DATE SIGNED 10-9-66 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10-11-1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY Allison Cemetery | | 23d. LOCATION (City, town or county) (State) Allisonia, Virginia | |
| 24. FUNERAL DIRECTOR Nalleys Funeral Home | | ADDRESS Mt Rainier, Md | |
| 25a. REC'D BY REGISTRAR DATE OCT 13 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

2534

2521

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14625

CERTIFICATE OF DEATH

14626

| | | | | | | | |
|--|---|--|---|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>
c. LENGTH OF STAY IN lb
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Leland Memorial Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Heights</u> 161
d. STREET ADDRESS <u>5402 Emerson Street</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Carrie</u> <u>Amber</u> <u>Pease</u>
First Middle Last | | | 4. DATE OF DEATH <u>10</u> <u>8</u> <u>19 66</u>
Month Day Year | | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>6-23-95</u> | | 9. AGE (In years last birthday) <u>71</u> yrs.
IF UNDER 1 YEAR: Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maine</u> | | | |
| 13. FATHER'S NAME
<u>Charles A. Bragg</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Ida Cochran</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>none</u> | | 17. INFORMANT <u>William H. Pease</u> Address <u>Same as #2</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>4201</u> IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>
DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>IMMEDIATE</u>
<u>3 years</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-2</u> , 19 <u>63</u> , to <u>present</u> , 19 <u>66</u> , that (I) (we) lost the deceased alive on <u>7-23</u> , 19 <u>66</u> , and that death occurred on <u>10-8</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>C. J. Harrison</u> | | | 22b. DATE SIGNED
<u>10-8-66</u> | | 22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>10/11/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Ft. Lincoln</u> | | | |
| 24. FUNERAL DIRECTOR <u>Francis Gasch's Sons Hyattsville, Md.</u> ADDRESS | | | 25a. REC'D BY REGISTRAR DATE <u>OCT 11 1966</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |
| 23d. LOCATION (City or Town) (County) (State)
<u>Colmar Manor P. G. Md.</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Certification by Dr. Harrison

14622

14622



... ..

... ..

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14626

CERTIFICATE OF DEATH

14627

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
6 hrs. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Seat Pleasant |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | d. STREET ADDRESS
507 69th Place | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Barbara Middle Phillips Last Phillips | | 4. DATE OF DEATH
Month October Day 29 Year 1966 | |
| 5. SEX
Female | 6. COLOR OR RACE
Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 30, 1939 |
| 9. AGE (In years last birthday)
27 yrs. | | 10. IF UNDER 1 YEAR
Months 27 Days 27 Hours 27 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country)
Washington, D. C. |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Nathaniel James | |
| 14. MOTHER'S MAIDEN NAME
Arzalia Butler | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Arzalia Butler, 428 O. St. Wash, D. C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured berry aneurism
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Oct. 29, 1966 , to Oct. 29, 1966 , that (I) (we) last saw the deceased alive on Oct. 29, 1966 , and that death occurred at 8:15M , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>John P. Paveau</i> | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22b. DATE SIGNED |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
11-4-66 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat. Cem. | 23d. LOCATION (City or Town) (County) (State)
Arlington, Va. |
| 24. FUNERAL DIRECTOR
<i>Frozen Funeral Home</i> | | 25a. REC'D BY REGISTRAR
NOV 3 1966 | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14833

REPORT OF DEATH

14833

NAME

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

DATE OF BIRTH

DATE OF DEATH

DATE OF DEATH

SEX

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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DATE OF DEATH

DATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

14627

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14628

| | | | | | | | |
|--|---|---|---|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George's</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>
c. LENGTH OF STAY IN 1b <u>20 days</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u> <u>16.1</u>
d. STREET ADDRESS <u>General Delivery</u>
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Katie Mildred Pinkney</u> | | | 4. DATE OF DEATH
Month Day Year
<u>10 28 19 66</u> | | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
<u>18 June 1903</u> | | 9. AGE (In years last birthday) <u>63</u> yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | | |
| 13. FATHER'S NAME
<u>Henry Pinkney</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Minnie Hawkins</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT Address
<u>Carlos Pinkney Upper Marlboro, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Left frontal parietotemporal subdural</u>
<u>9369</u> DUE TO <u>hematoma with compression of underlying cortex.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>unknown</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>unknown</u> <u>unknown</u> | | 20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not While at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>unknown</u> | | | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>John Kehoe</u> M.D.
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u> | | | 22. DATE SIGNED
<u>10-30-66</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>11-2-66</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Union Meth. Cemetery</u> | | | |
| 23d. LOCATION (City or Town) _____ (County) _____ (State) _____
<u>Upper Marlboro, Md.</u> | | 24. FUNERAL DIRECTOR ADDRESS
<u>Rollins Funeral Home 4339 Hunt Pl., N.E.</u> | | | | | |
| 25a. REC'D BY REGISTRAR DATE <u>NOV 3 1966</u> | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14627

14627

RECEIVED

Henry Linney

Linney

Colon Linney, Union, Nebraska, Mo.

June

Union, Nebraska, Mo.

June 21, 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14628

CERTIFICATE OF DEATH

14629

| | | | |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN lb
4 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville | | d. STREET ADDRESS
5700 16th Avenue | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Everett R Poindexter | | 4. DATE OF DEATH
Month Day Year
October 20 1966 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4-24-1914 |
| 9. AGE (In years last birthday)
52 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY
grayhound Co. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William F. Poindexter | | 14. MOTHER'S MAIDEN NAME
Mary Glass | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
Unk. | |
| 17. INFORMANT
Sheridan, Ranson & Smith Funeral Home | | Address: Kent Store, Va. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Right coronary artery Occlusion with
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial infarction
DUE TO (c) generalized atherosclerosis | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 1966 , to Oct 20 1966 , that (I) (we) lost the deceased alive on Oct 19 1966 , and that death occurred at 2:00 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. Irvin M. Grassgreen | | 22b. DATE SIGNED
10-20-66 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Irvin M. Grassgreen | | 22d. ADDRESS
3101 Arundel Rd., Mr. Rainier, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/22/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Louisa, Virginia | |
| 24. FUNERAL DIRECTOR
Murphy Funeral Home, Arlington, Va. | | 25a. REC'D BY REGISTRAR
OCT 24 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

14632

CERTIFICATE OF SALE

14632

SALE

SALE

SALE

SALE

SALE

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SALE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14629

CERTIFICATE OF DEATH

14630

| | | | |
|---|--------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Pro George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Riverdale, Md. | | c. LENGTH OF STAY in 1b
D. O. A. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Leland Memorial Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Ilia M. Priester | | 4. DATE OF DEATH
Month Day Year
Oct 13, 1966- 19 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept 10, 1903 |
| 9. AGE (In years last birthday)
63 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Saleslady | | 11b. KIND OF BUSINESS OR INDUSTRY
Dept Store | |
| 12. BIRTHPLACE (County & State, or foreign country)
South Carolina | | 13. CITIZEN OF WHAT COUNTRY?
U S A | |
| 14. FATHER'S NAME
Robert Davis | | 15. MOTHER'S MAIDEN NAME
Eugina Black | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 17. SOCIAL SECURITY NO.
579-22-0033 | |
| 18. INFORMANT
Betty M. Parker | | Address
Hyattsville, Md. | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute myocardial infarction
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) auricular fibrillation
DUE TO
(c) arterio sclerotic heart disease. | | INTERVAL BETWEEN ONSET AND DEATH
1962
years. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7:26 , 19 62 , to Oct 10 , 19 66 , that (I) (we) last saw the deceased alive on 10/10 , 19 66 , and that death occurred at 4:48 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
E.H. Markwood | | 22b. DATE SIGNED
10/14/66 | |
| 22c. PHYSICIAN'S NAME (Type)
Emmett H. Markwood, M. D. | | 22d. ADDRESS
3208 17th Street, N. W. Washington, D. C. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial Transit | 23b. DATE THEREOF
10/16/66 | 23c. NAME OF CEMETERY OR CREMATORY
Fairfax Cemetery | 23d. LOCATION (City or Town) (County) (State)
Fairfax, South Carolina |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons | | 25a. REC'D BY REGISTRAR
DATE OCT 17 1966 | |
| ADDRESS
Hyattsville, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

VR A15 (4)
20 M 1-66

Jwb

140341

OFFICE OF DEAN

140341

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G383 11/25/66 mh

14630

CERTIFICATE OF DEATH

14631

| | | | | | | | |
|--|----------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland b. COUNTY
Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | c. LENGTH OF STAY IN 1b
20 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cedar Heights | | | 16.1 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | | | d. STREET ADDRESS
1010 64th Avenue | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Arthur P Prince | | | | 4. DATE OF DEATH
Month Day Year
October 27 1966 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | B. DATE OF BIRTH
Nov. 4, 1937 | 9. AGE (In years last birthday)
29 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Janitor | | 10b. KIND OF BUSINESS OR INDUSTRY
School | | 11. BIRTHPLACE (County & State, or foreign country)
Washington D.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
David Prince | | | | 14. MOTHER'S MAIDEN NAME
Beatrice Colston | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
5400 | | 17. INFORMANT
DAVID Prince Same as 2D Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage Shock
DUE TO bleeding
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) large perforating, penetrating, duodenal ulcer
DUE TO (c) gastric ulcer | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (X) (this hospital) attended the deceased from October 8, 1966 , to October 27, 1966 that (X) (we) last saw the deceased alive on October 27, 1966 , and that death occurred at 1:45 M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Dr. Lee Lacer | | | | ATTENDING PHYS. <input type="checkbox"/> MED. AM DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
10-27-66 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Lee Lacer | | | | 22d. ADDRESS
Prince George's Genl. Hosp., Cheverly Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
11-1-66 | | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Highland Park Md | | |
| 24. FUNERAL DIRECTOR
H.S. Washington & Sons 4925 Pearce Ave N.E. | | | | 25a. REC'D BY REGISTRAR
DATE NOV 3 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

14631

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14631

14632

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
<u>Prince George</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Beltsville</u>
c. LENGTH OF STAY IN 1b
<u>Minutes</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Old Baltimore Pike</u> | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE
<u>Md.</u>
b. COUNTY
<u>Prince George</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Beltsville</u>
d. STREET ADDRESS
<u>114080 Old Baltimore Pike</u>
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
<u>First</u>
<u>Albert</u> | | 4. DATE OF DEATH
<u>Month</u>
<u>10</u>
<u>Day</u>
<u>9</u>
<u>Year</u>
<u>1966</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
<u>12 July 1918</u>
<u>48</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Edward Ragsdale</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Edmondson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Subdural and subarachnoid hemorrhage</u>
983X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) <u>Depressed skull fracture-rt. temporal</u>
DUE TO (c) <u>Blunt trauma to head</u>
Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Struck on head by assailant</u> | |
| 20c. TIME OF INJURY
Month, Day, Year
<u>12:30</u> <u>a.m.</u>
<u>10 9 66</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Used car junkyard, Old Balt Pike, P.G. Md.</u> | | 20f. (City or town) (County) (State)
<u>Prince George</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>John Kehoe</u>
EXAMINER'S NAME (Type)
<u>John Kehoe, M.D., Riverdale</u> | | 22. DATE SIGNED
<u>10-10-66</u>
Address (Street, city, town, or county)
<u>Shaw Rd. N.E. Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>10-15-66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Hammock Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Shaw Rd. N.E. Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>John D. Watson</u>
ADDRESS
<u>3435-14 St. NW Wash D.C.</u> | | 25. REC'D BY REGISTRAR
DATE
<u>OCT 20 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

10001

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14632

CERTIFICATE OF DEATH

14633

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 2 hrs. 15 min. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | d. STREET ADDRESS 8330 Quentin St. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Baby Boy Middle Reid Last Reid | | 4. DATE OF DEATH
Month Oct Day 8 Year 1966 | |
| 5. SEX Male | 6. COLOR OR RACE Cauc. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 7, 1966 |
| 9. AGE (in years last birthday) 2 yrs. 15 Months 2 Days 15 Min. | | 10. BIRTHPLACE (County & State, or foreign country) Prince George's Maryland | |
| 11. CITIZEN OF WHAT COUNTRY? U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Patrick Charles Reid | | 14. MOTHER'S MAIDEN NAME Patricia Ellen Noe | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. -- | |
| 17. INFORMANT Mother | | Address as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 776x DUE TO Immaturity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Immaturity DUE TO Immaturity
(c) Immaturity | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10-7 , 19 66 , to 10-8 , 19 66 , that (I) (we) last saw the deceased alive on 10-8 , 19 66 and that death occurred at 12:25A M, from causes and on the date stated above. | | 22a. SIGNATURE Bernardo Alvarado, M.D. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22b. DATE SIGNED 10-13-66 | | 22c. PHYSICIAN'S NAME (Type) Bernardo Alvarado, M.D. | |
| 22d. ADDRESS 6201 Riverdale Rd., Riverdale, Md. | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | |
| 23b. DATE THEREOF 10/29/66 | | 23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. | |
| 23d. LOCATION (City or Town) (County) (State) Cheverly Maryland | | 24. FUNERAL DIRECTOR Harvey W. Penn, Jr., Administrator, Cheverly, Md. | |
| 25a. REC'D BY REGISTRAR NOV 1 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

14033

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14633

CERTIFICATE OF DEATH

14634

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FORESTVILLE NURSING HOME</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>P.G.</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>UPPER MARLBORO 16-1</u>
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Loretta</u> Middle <u>Gertrude</u> Last <u>Ridgely</u> | | 4. DATE OF DEATH
Month <u>10</u> Day <u>9</u> Year <u>1966</u> | | 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>12/19/05</u>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (In years last birthday) <u>60</u> yrs.
IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>COURT</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>P.G., MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>JOHN FRANCIS RIDGELY</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ESTELLA E. SELTZER</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. <u>218-38-8737</u> | |
| 17. INFORMANT <u>UPPER</u> | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>
Conditions, if any, which gave rise to immediate cause (b) <u>4201</u>
(a), stating the underlying cause last. (c) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Renal insufficiency. Psych.</u> | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>10</u> p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 1966</u> to <u>10/9</u> 1966 , that (I) (we) last saw the deceased alive on <u>10/9</u> 1966 , and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>L. Clark Holmes</u> M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED
<u>10/9/66</u> | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | | 22d. ADDRESS
<u>FORESTVILLE, MD.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>10-12-66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>MT CARMEL</u> | | 23d. LOCATION (City, town or county) (State)
<u>UPPER MARLBORO, MD.</u> | | | | | |
| 24 FUNERAL DIRECTOR'S SIGNATURE
<u>HUNTT FUNERAL HOME</u> | | | | | | ADDRESS
<u>WALDORF, MD.</u> | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |
| DATE <u>OCT 14 1966</u> | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14634

14635

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lanham, Md.</u> | | c. LENGTH OF STAY IN 1b
<u>16-1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Magnolia Nursing Home</u> | | d. STREET ADDRESS
<u>4712 67TH AVE.</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Carrie</u> Middle <u>Louelle</u> Last <u>Rust</u> | | 4. DATE OF DEATH
Month <u>Oct.</u> Day <u>6</u> Year <u>1966</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>12/10/1879</u> |
| 9. AGE (In years lost birthday) <u>86</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Shellman Cooper</u> | | 14. MOTHER'S MAIDEN NAME
<u>Susan Catherine Cooper</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None as #2 Daughter</u> | |
| 17. INFORMANT
<u>Helen Temple</u> | | Address
<u>Same as #2 Daughter</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u>
157X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CANCER OF PANCREAS</u> DUE TO
(c) <u>3 months</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>19</u> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/6/66</u> , 19 <u>66</u> , to <u>10-6-66</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10/6</u> 19 <u>66</u> , and that death occurred at <u>4:30</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Dr. L. L. Rust</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>10/8/66</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Pleasant</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Taylors Town Loudon Va.</u> |
| 24. FUNERAL DIRECTOR
<u>Francis Gasch's Sons Hyattsville, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>OCT 7 1966</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

MEDICAL CERTIFICATION

14033

RECEIVED OF DEPT

14033

Blank ledger page with horizontal ruling lines and two punch holes on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14635

CERTIFICATE OF DEATH

14636

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
3 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hillside | | d. STREET ADDRESS
1520 59th Avenue | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Kimon M Santos | | 4. DATE OF DEATH
Month Day Year
October 19 1966 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 22, 1896 |
| 9. AGE (In years last birthday)
70 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cook | | 10b. KIND OF BUSINESS OR INDUSTRY
Restaurant | |
| 11. BIRTHPLACE (County & State, or foreign country)
Greece | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Kimon Santos | | 14. MOTHER'S MAIDEN NAME
Elizabeth-- | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
Hospital Records | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Right coronary artery occlusion with
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial infarction
DUE TO (c) Arteriosclerotic Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (s) (this hospital) attended the deceased from October 16, 1966 , to October 19, 1966 , that (s) (we) last saw the deceased alive on October 19, 1966 , and that death occurred at 7:15 P M , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
A. Clark Holmes, M.D. | | 22b. DATE SIGNED
10/20/66 | |
| 22c. PHYSICIAN'S NAME (Type)
A. Clark Holmes, M.D. | | 22d. ADDRESS
4108 Pratt St. Upper Marlboro, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/22/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Glenwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. | |
| 24. FUNERAL DIRECTOR
Jas. T. Ryan, Inc. | | 25a. REC'D BY REGISTRAR
317 Pa. Ave., SE DC | |
| 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | DATE
OCT 24 1966 | |

14636

STATE OF TEXAS

14637

County of _____
State of _____
I, _____, County Clerk of said County, do hereby certify that _____
is the owner of the _____
situated in _____
County of _____
State of _____
and that the same is subject to a lien in favor of _____
for the sum of _____ Dollars.

USA

Witness my hand and the seal of said County at _____
this _____ day of _____, 19____.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14636

14637

| | | | | | | | |
|---|--|----------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5405 Walls Lane 16-1</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u> | | | | d. STREET ADDRESS <u>Suitland Md</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>JAMES RONOLD SCHAEFER</u> | | | | 4. DATE OF DEATH <u>Oct 3 1966</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug 26 1938</u> | |
| 9. AGE (In years last birthday) <u>28</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | 9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FBX installer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone</u> | | 11. BIRTHPLACE (State or foreign country) <u>Washington DC</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>Joseph William Schaefer</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Edna Owens</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. <u>220-34-3361</u> | | | | 17. INFORMANT <u>Mrs. Patricia Schaefer</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Lacerations & Contusions</u>
976X DUE TO (b) <u>(Gun Shot Wound)</u> instant
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH. | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Gun Shot Wound of Head</u> | | | | 20c. TIME OF INJURY Month, Day, Year <u>9:00 a.m. Oct 3 1966</u> | | | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | | |
| 20f. (City or town) <u>Suitland Pr Geo Md</u> (County) (State) | | | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Darton Owatkins</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 5318 Annapolis Rd. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Bladensburg, Md. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-3-66 | | | |
| EXAMINER'S NAME (Type) <u>DARTON OWATKINS</u> | | | | Address (Street, city, town, or county) <u>10-3-66</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>10/6/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Prince Georges, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Wilhelm Funeral Home</u> ADDRESS <u>4308 Suitland Rd. Suitland Md.</u> | | | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>OCT 6 1966</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14031

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14031

FOR STATE
HEALTH DEPT.

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Usual residence: _____
7. Cause of death: _____
8. Manner of death: _____
9. Signature of medical examiner: _____
10. Date: _____

11. Signature of registrar: _____
12. Date: _____

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14637

14636

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | c. LENGTH OF STAY IN lb
D.O.A. | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | | | d. STREET ADDRESS
6509 Landover Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Leonard Middle W Last Secrist | | | | 4. DATE OF DEATH
Month October Day 7 Year 1966 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
26 JULY 1907 | |
| 9. AGE (In years last birthday)
59 yrs. | | 10. IF UNDER 1 YEAR
Months Days | | 11. IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
AUTOMOBILE MECHANIC | | | | 10b. KIND OF BUSINESS OR INDUSTRY
HANDLEY FORD CO | | 11. BIRTHPLACE (County & State, or foreign country)
VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | | | | | | |
| 13. FATHER'S NAME
LETTIE SECRIST | | | | 14. MOTHER'S MAIDEN NAME
MATTIE E. DAVIS | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
579-01-0180 | | 17. INFORMANT
ELIZABETH V. SECRIST Address SAME AS #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute Myocardial Infarction
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (was not) attended the deceased from Dec. 27 , 1963, to Oct. 7 , 1966, that (I) (was) last saw the deceased alive on October 7 1966, and that death occurred at 4:40A M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Barry Rosenberg | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
October 7, 1966 | |
| 22c. PHYSICIAN'S NAME (Type)
Barry Rosenberg, M.D. | | | | 22d. ADDRESS
6501 Landover Rd., Cheverly, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
10 Oct 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
FORT LINCOLN CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
BLADENSBURG, MARYLAND | |
| 24. FUNERAL DIRECTOR
W.W. Chambers Co | | | | ADDRESS
Riversdale, Md. | | 25a. REC'D BY REGISTRAR
DATE OCT 10 1966 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14634

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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74

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|-------------------------|--|---|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 14638 | | | | | 14639 | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | |
| a. COUNTY | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | a. STATE | | b. COUNTY | | |
| Prince Georg'es | | Cheverly | | | Maryland | | Prince George's | | |
| c. LENGTH OF STAY IN 1b | | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | e. IS RESIDENCE ON A FARM? | | |
| 26 days | | Prince George's General Hospital | | | Upper Marlboro | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | | | | 4. DATE OF DEATH | | | | |
| First Middle Last | | | | | Month Day Year | | | | |
| Pauline B Sellman | | | | | October 14 19 66 | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) yrs. | |
| Female | | Negro | | | | 5-10-18 | | 48 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| None | | | | | | Prince George Co., Md. | | USA | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| Wilson Sellman | | | | | Unknown | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No | | | No | | Ethel Abrahms Bx. 2085 Upper Marlboro Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | |
| 157X DUE TO | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) DUE TO | | | | | | | | | |
| (c) DUE TO | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 19 | | | | | | | | | |
| 21. I certify that (s) (this hospital) attended the deceased from Sept. 19, 1966, to Oct. 14, 1966, that (I) (we) last saw the deceased alive on Oct. 14, 1966, and that death occurred at 1:40 M, from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | 22d. ADDRESS | | | | |
| Jose A. Garcia, M.D. | | | | | Prince George's Genl. Hosp., Cheverly Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | | 10-18-66 | | Moses Cemetery | | | Anne Arundel Co., Md. | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Rollins, Inc. | | | | | 4339 Hunt Pl., N.E. Wash., D.C. | | DATE OCT 18 1966 | | |

VR A15 (4)
20 M 1/66

46341

2234T

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|---|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 14639 | | | | CERTIFICATE OF DEATH | | | 14640 | | |
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY IN 1b
1 mo. 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville
d. STREET ADDRESS
4015 Nicholson Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Bernard P SHIELDS | | | | | 4. DATE OF DEATH
Month Day Year
October 19 19 66 | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10-21-78 | | 9. AGE (In years lost birthday)
87 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Section Quartermaster | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Government | | 11. BIRTHPLACE (County & State, or foreign country)
Washington D. C. | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | |
| 13. FATHER'S NAME
Samuel E. Shields | | | | | 14. MOTHER'S MAIDEN NAME
Josephine Stone | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
220 44 5817 | | 17. INFORMANT Address
Bernard F. Shields same as #2 (son) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli w/ dysfunction
DUE TO Cerebral dysfunction
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) Generalized Atherosclerosis
DUE TO (c) Generalized Atherosclerosis | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (this hospital) attended the deceased from Aug. 2, 1965 to 10-19, 1966 , that (we) lost saw the deceased alive on 10-19, 1966 , and that death occurred at 1:45 PM , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
R.D. Bauer M.D. | | | | 22b. DATE SIGNED
10-19-66 | | 22c. PHYSICIAN'S NAME (Type)
R.D. Bauer, M.D. | | | |
| 22d. ADDRESS
2515 Buck Lodge Rd. Catonsville, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/22/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet | | | 23d. LOCATION (City or Town) (County) (State)
Washington D. C. | | |
| 24. FUNERAL DIRECTOR
Francis Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR
DATE OCT 24 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

01011

REPORT TO DIRECTOR

SECRET

1. The following information was received from the source on 10/10/54:

2. The source has been advised that the following information is being furnished to you for your information:

3. The source has been advised that the following information is being furnished to you for your information:

4. The source has been advised that the following information is being furnished to you for your information:

5. The source has been advised that the following information is being furnished to you for your information:

6. The source has been advised that the following information is being furnished to you for your information:

7. The source has been advised that the following information is being furnished to you for your information:

8. The source has been advised that the following information is being furnished to you for your information:

9. The source has been advised that the following information is being furnished to you for your information:

10. The source has been advised that the following information is being furnished to you for your information:

11. The source has been advised that the following information is being furnished to you for your information:

12. The source has been advised that the following information is being furnished to you for your information:

13. The source has been advised that the following information is being furnished to you for your information:

14. The source has been advised that the following information is being furnished to you for your information:

15. The source has been advised that the following information is being furnished to you for your information:

16. The source has been advised that the following information is being furnished to you for your information:

17. The source has been advised that the following information is being furnished to you for your information:

18. The source has been advised that the following information is being furnished to you for your information:

19. The source has been advised that the following information is being furnished to you for your information:

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14640

14641

| | | | |
|---|-----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE District of Columbia
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| c. LENGTH OF STAY IN TB DOA | | d. STREET ADDRESS Naval Air Facility Barracks | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Billy Edward Simpson | | 4. DATE OF DEATH 10 23 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 28 July 1936 |
| 9. AGE (In years last birthday) 30 Yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy | |
| 11. BIRTHPLACE (State or foreign country) Texas | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Billy H. Simpson | | 14. MOTHER'S MAIDEN NAME Alice Horan | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. Active Duty Unknown | |
| 17. INFORMANT Alice Albritton | | Address Okla City Oklahoma | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemothorax, left chest
8234
DUE TO Laceration of left lung
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO From fracture of sternum and multiple fractures of skull
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Driver of car which ran off road and hit guard rail. | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:25am p.m. 10-23- 19 66 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 495 south of Balt. Wash. Parkway. | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | Address (Street, city, town, or county) 10-24-66 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 10/26/66 | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memory Gardens | 23d. LOCATION (City or Town) (County) (State) Okla. City, Oklahoma |
| 24. FUNERAL DIRECTOR W.W. Chambers Co., Inc. 1400 Chapin St. N.W. | | 25a. REC'D BY REGISTRAR OCT 31 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1451

1451

U.S.A.

Texas

U.S.A.

Section

Alice Moran

Billy H. Simpson

U.S.A.
Oklahoma

Alice Albritton

Active duty unknown

Yes

Serial 10/20/60 Illinois Henry Gansons Oklahoma

W.W. Chambers Co., Inc. 1400 Chapin, N.Y.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14641 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14643

| | | | |
|--|------------------------|--|----------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly DOA | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Deanwood Park 161 | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital | | d. STREET ADDRESS 1411 Eastern Avenue | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Joseph Cecil Smith | | 4. DATE OF DEATH Month 10 Day 8 Year 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-20-1919 |
| 9. AGE (in years last birthday) 47 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Wade Smith | | 14. MOTHER'S MAIDEN NAME Susie Ashwell | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Rosalee Smith-1411 Eastern Avenue | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma
157 x DUE TO Carcinoma of pancreas
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH over 2 mo. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | 22. DATE SIGNED 10-10-66 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10/15/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park | | 23d. LOCATION (City, town or county) Maryland | |
| 24. FUNERAL DIRECTOR John T. Stewart | | 25a. REC'D BY REGISTRAR OCT 13 1966 | |
| Stewart Funeral Home-4001 Benning Road, N.E. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

14000

MEMORANDUM FOR THE SECRETARY OF THE ARMY

14000

14000

[Handwritten signature]

Very truly yours,

John Edgar Hoover, Director

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|--|--|---|---|---|--|---|--------------------------------------|--|--|
| 14642 | | | | | 14644 | | | | |
| Item #102 File #382 10/25/66 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
PRINCE GEORGE'S MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND b. COUNTY
PRINCE GEORGE'S | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
ANDREWS AIR FORCE BASE | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
CAMP SPRINGS | | | | |
| c. LENGTH OF STAY IN 1b
186 DAYS | | | | | d. STREET ADDRESS
5316 HENDERSON ROAD S.E. | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
USAF HOSPITAL ANDREWS | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print) LAWRENCE | | | First Middle Last
RAYMOND SMITH | | | 4. DATE OF DEATH
Month Day Year
OCTOBER 21 1966 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
CAUCASIAN | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8 MAY 1913 | | 9. AGE (In years last birthday) 53 yrs.
IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SEAMAN aviation machine | | | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. NAVY | | 11. BIRTHPLACE (County & State, or foreign country)
HUGHESVILLE, PA. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JACOB MELVIN SMITH | | | | | 14. MOTHER'S MAIDEN NAME
MINNIE (UNKNOWN) CASSELBERRY | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) YES | | | 16. SOCIAL SECURITY NO.
1931-1959 | | 17. INFORMANT
GRACE E SMITH-WIFE-SAME AS #2 ABOVE | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RETICULAR CELL SARCOMA
2000 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 18 APR , 19 66 , to 21 OCT , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 21 OCT , 19 66 , and that death occurred at 9:05 from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<i>Frederick L. Sachs</i> M.D. | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
21 OCT 66 | | |
| 22c. PHYSICIAN'S NAME (Type)
FREDERICK L. SACHS, CAPT, USAF, MC | | | | | 22d. ADDRESS
USAF HOSPITAL ANDREWS, ANDREWS AFB, WASHINGTON DC 20331 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/25/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City, town or county) (State)
Prince Georges, Maryland | | | |
| 24. FUNERAL DIRECTOR
Wilhelm Funeral Home 4308 Suitland Rd. Suitland Md. | | | | | 25a. REC'D BY REGISTRAR
OCT 25 1966 | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | |

14514

14514

PRINCE GEORGE'S MARYLAND BRUCE GEORGE'S

ARRIVED AIR FORCE BASE 185 DAYS CAMP SPRINGS

USAF HOSPITAL ANDREWS 2015 HENDERSON ROAD S.E.

LAWRENCE MAYNARD SMITH OCTOBER 21 1965

MALE CAUCASIAN 9 MAY 1913

SEAMAN JAMES W. S. NAVY BUSHSVILLE, W. V. U.S.A.

JAMES HEWITT SMITH MINNIE (UNKNOWN) CARROLLTON

1917-1938 875-10-15 STAGE 1 BIRTH-DEATH-AM 21 1938

RECURRING DEATH RECORD

X

X 10 APR 1965 21 OCT 1965 X

21 OCT 1965

USAF HOSPITAL ANDREWS ANDREWS AIR WASHINGTON DC 20331

PRINCE GEORGE'S MARYLAND BRUCE GEORGE'S

001

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div>Items 18-21 Film 382 11-7-66</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>14643 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14645</div> | | | | | | | | | |
|---|--|----------------------------------|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | c. LENGTH OF STAY IN 1b
DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Temple Hills | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George General Hospital | | | | | d. STREET ADDRESS
6430 Gull Road | | | | |
| 3. NAME OF DECEASED
(Type or print)
First Leonard Middle Vincent Last Smith, Jr. | | | 4. DATE OF DEATH
Month 10 Day 17 Year 1966 | | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
14 May 1948 | | 9. AGE (In years last birthday) 18 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Surveyor Group | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Washington, DC | | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Leonard V. Smith, Sr | | | | | 14. MOTHER'S MAIDEN NAME
Rosalie K. Parks | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Leonard V. Smith, Sr. Address Same as Item #2 | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Barbiturate intoxication
970.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Ingested overdose of barbiturates | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 10-17 19 66
p.m. | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
Temple Hills Pr. Geo. Md. | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
John Kehoe | | | | | M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | | 22. DATE SIGNED
10-17-66 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
Oct. 20, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l. Cemetery | | | 23d. LOCATION (City, town or county) (State)
Arlington, Va. | |
| 24. FUNERAL DIRECTOR
Simmons Bros. | | | | | 25a. REC'D BY REGISTRAR
OCT 19 1966 | | | | |
| ADDRESS
1661-Good Hope Rd SE Wash DC | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

1963

1963

[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|----------------------------------|--|--|--|--|---|---|--|---|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| Item #7 Film #G381 10/7/66 pc | | | | | | | | | |
| Items #7, 8 & 9 Film #G382 10/26/66 pc | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | c. LENGTH OF STAY IN lb
7 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Capitol Heights | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | | | | d. STREET ADDRESS
6119 C St. | | | | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle C. Last Smith | | | | | 4. DATE OF DEATH
Month October Day 1 Year 19 66 | | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> / NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11/15/74/1892 | | 9. AGE (In years lost, birthday)
74/ 73 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Domestic | | 11. BIRTHPLACE (County & State, or foreign country)
Austria - Hungary | | | 12. CITIZEN OF WHAT COUNTRY?
No | | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT
Hospital Records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute peritonitis with Rt subdiaphragmatic abscess
DUE TO (b) Probable carcinoma of gall bladder with extension
DUE TO (c) to the liver transverse colon. | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 9/24/66 , 19 66 , to Oct. 1 , 19 66 , that (I) (we) last saw the deceased alive on October 1 19 66 , and that death occurred at 2:15 M , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<i>Peter Duus</i> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
10-1-66 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Peter Duus, M.D. | | | | 22d. ADDRESS
6124 Central Ave., Capitol Hgts., Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Oct. 5-1966 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Bladensburg, Maryland | | | |
| 24. FUNERAL DIRECTOR
<i>Simmons Bros</i> | | | | ADDRESS
Wash., DC. | | 25a. REC'D BY REGISTRAR
OCT 5 1966 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |
| Simmons Bros. Funeral Home 1661-Gd. Hope Rd. SE | | | | | | | | | |

32841

2221

1. *Staphylococcus aureus*

Copyright Clearance Center

Refined German's General Hospital

512

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22

2015

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|------------------|---|--|------------------------------------|--|--|--------------------------------------|---|------|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 14645 | | | | | 14647 | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | |
| a. COUNTY | | Prince George's | | | a. STATE | | Maryland | | |
| | | MARYLAND | | | | | b. COUNTY Prince George's | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | |
| Cheverly | | | | 9 days | | E. Riverdale 16.1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Prince George's General Hospital | | | | | 5516 Madison Street | | | | |
| 3. NAME OF DECEASED (Type or print) | | | First Middle Last | | 4. DATE OF DEATH | | | | |
| Grace | | | M. Snider | | Month Day Year
October 8, 1966 | | | | |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | White | WIDOWED <input checked="" type="checkbox"/> | DIVORCED <input type="checkbox"/> | 7/7/06 | 60 | Months | Days | Hours | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | |
| HOUSEWIFE | | | OWN HOME | | WASHINGTON D.C. | | | U.S. | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| CLARENCE CHALK | | | | | UNKNOWN | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| NO | | | | | JOYCE M. MCCOY 209 SOUTH MAIN ST. ADDRESS
MOOREFIELD WEST. VA. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 410X DUE TO Congestive Heart Failure
(b) RHEUMATIC Heart Disease
(c) DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from September 29, 1966, to Oct. 8, 1966, that (I) (we) last saw the deceased alive on Oct. 8, 1966, and that death occurred at 2:10 PM, from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
A. Clark Holmes, M.D. | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
10/8/66 | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | 22d. ADDRESS | | | | |
| A. Clark Holmes, M.D. | | | | | 4108 Pratt St., Upper Marlboro, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 10-12-66 | | WASHINGTON NATIONAL | | SPITLAND. MD | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| W.W. Chambers Co Riverdale Md. | | | | | DATE OCT 13 1966 | | Charles Judge | | |

13041

2022

Figure 1. *Staphylococcus aureus* strains used in this study.

212

A. Clark Holmes

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14646

CERTIFICATE OF DEATH

14648

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY IN 1b
2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Capitol Heights
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Alex V Sorenson | | 4. DATE OF DEATH
Month Day Year
October 13 1966 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 21, 1905 |
| 9. AGE (In years last birthday)
61 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PAINTER (RETIRED) | | 10b. KIND OF BUSINESS OR INDUSTRY
UNK | |
| 11. BIRTHPLACE (County & State, or foreign country)
UNK | | 12. CITIZEN OF WHAT COUNTRY?
UNK | |
| 13. FATHER'S NAME
UNK. | | 14. MOTHER'S MAIDEN NAME
UNK. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MRS. L. Thompson | | Address
510 61st Ave Capitol Heights, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 576X
DUE TO Intestinal obstruction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Peritonitis
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Hydrocephalus | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that he (this hospital) attended the deceased from October 11, 1966 , to October 13, 1966 that he (we) last saw the deceased alive on October 13, 1966 , and that death occurred at 6:30 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
A. Clark Holmes | | 22b. DATE SIGNED
10/13/66 | |
| 22c. PHYSICIAN'S NAME (Type)
A. Clark Holmes, M.D. | | 22d. ADDRESS
4108 Pratt St. Upper Marlboro, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
CREMATION | | 23b. DATE THEREOF
Oct. 17, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
LEE FUNERAL HOME | | 23d. LOCATION (City or Town) (County) (State)
WASHINGTON D.C. | |
| 24. FUNERAL DIRECTOR
LEE FUNERAL HOME | | 25a. REC'D BY REGISTRAR
300 4th St. N.E. Wash DC | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE
OCT 18 1966 | |

1962

RECEIPT OF DEATH

1101

Received of the estate of the deceased the sum of \$100.00

for the funeral expenses of the deceased

the sum of \$100.00

for the funeral expenses of the deceased

the sum of \$100.00

for the funeral expenses of the deceased

the sum of \$100.00

for the funeral expenses of the deceased

the sum of \$100.00

for the funeral expenses of the deceased

the sum of \$100.00

for the funeral expenses of the deceased

the sum of \$100.00

for the funeral expenses of the deceased

the sum of \$100.00

for the funeral expenses of the deceased

the sum of \$100.00

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chillum</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | |
| c. LENGTH OF STAY IN 1b <u>1 hr</u> | | d. STREET ADDRESS <u>7608 - 25 ave</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>MORRIS RAY SPITSZER</u> | First Middle Last | 4. DATE OF DEATH <u>Oct 25</u> | Month Day Year <u>19 66</u> |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 17 1900</u> |
| 9. AGE (In years last birthday) <u>65</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>US Gov</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Cincinnati Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Joseph Spitszer</u> | | 14. MOTHER'S MAIDEN NAME <u>Esther Lubitz</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> | | 16. SOCIAL SECURITY NO. <u>2509-46001</u> | |
| 17. INFORMANT <u>Mrs. Rebecca Somner</u> | | Address <u>2509 Avalon pl Hyattsville</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>few hours</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular</u>
(c) <u>disease</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Dayton O. Watkins</u> | | M.O. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 5318 Ann. Police | |
| EXAMINER'S NAME (Type) <u>DAYTON O. WATKINS</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 23 Adams | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-2-66 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>10/3/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Gar.</u> | 23d. LOCATION (City, town or county) (State) <u>Falls Ch., Va.</u> |
| 24. FUNERAL DIRECTOR <u>Bernard Danzansky & Sons St., N.W. Wash. D.C.</u> | | 25a. REC'D BY REGISTRAR <u>OCT 3 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14032

14032

14032

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14648

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14650

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George's</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>
c. LENGTH OF STAY IN 1b <u>1 day</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3 Keel Place</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> 16.1
d. STREET ADDRESS <u>3 Keel Place</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>GLENN EUGENE STEVENSON</u> First Middle Last
4. DATE OF DEATH <u>Oct 2</u> Month Day Year <u>1966</u> | | | | 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 19 1946</u> 9. AGE (In years last birthday) <u>20</u> yrs. IF FUNER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police Officer US Air Force</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>PTA</u> 11. BIRTHPLACE (State or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>FRANK STEVENSON</u> 14. MOTHER'S MAIDEN NAME <u>VELMA HORTON</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service) <u>1964-1966</u> 16. SOCIAL SECURITY NO. <u>14-16-2654</u> 17. INFORMANT <u>Helda Steven</u> Address <u>3 Keel Place Laurel Md</u> | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Accidental Chest Wound to Lungs</u>
976X OUE TO (b) <u>Gun Shot Wound</u> instant
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subject under treatment for metastatic Cancer</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) <u>Subject shot self with shot gun</u> 20c. TIME OF INJURY Month, Day, Year <u>3-2-1966</u> Hour a.m. <u>3:30</u> p.m. <u>3:30</u> 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not While <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Laurel</u> (County) <u>Prince Geo</u> (State) <u>Md</u> | | | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Dayton O Watkins</u> EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u> 22. DATE SIGNED <u>10-2-66</u> 3318 <u>Bladensburg Md</u> | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>10/5/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> 23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Arthur K. Korman</u> ADDRESS <u>Laurel, Md.</u> 25a. REC'D BY REGISTRAR <u>Oct 3 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | |

14628

MEDICAL EXAMINATION REPORT OF DOCTOR

14628

14628

REPORT OF DOCTOR
NAME OF PATIENT
DATE OF EXAMINATION
PLACE OF EXAMINATION
NAME OF PHYSICIAN
ADDRESS OF PHYSICIAN
CITY AND STATE
FINDINGS
DIAGNOSIS
TREATMENT
PROGNOSIS
REMARKS

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14649

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14651

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Riverdale | |
| c. LENGTH OF STAY IN lb DOA | | d. STREET ADDRESS 5513 Nicholson Street, Apt. 103 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Herman Jacob Svoboda | | 4. DATE OF DEATH Month Day Year 10 23 1966 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 13 Nov. 1921 |
| 9. AGE (In years lost birthday) 44 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Baltimore Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Svoboda | | 14. MOTHER'S MAIDEN NAME Viola Schutz | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II | | 16. SOCIAL SECURITY NO. 578 12 5220 | |
| 17. INFORMANT Viola Svoboda | | Address Same as #2 (mother) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
4200 DUE TO Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs. |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | 22. DATE SIGNED 10-24-66 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, or other disposal (Specify) Burial | 23b. DATE THEREOF 10/27/66 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | 23d. LOCATION (City or Town) (County) (State) Arlington Arlington, Va. |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md. | | 25a. REC'D BY REGISTRAR OCT 27 1966 25b. REGISTRAR'S SIGNATURE Francis Judge | |

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...of livestock and dairy farms

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | |
|--|-------------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
10/7/66 | 23c. NAME OF CEMETERY OR CREMATORY
Lynnhurst Cemetery | 23d. LOCATION (City or Town) (County) (State)
Knoxville, Tenn. |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home
4308 Suitland Rd. Suitland, Md. | | 25a. REC'D BY REGISTRAR
DATE OCT 6 1966 | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |

| | | | |
|---|---|---|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary Edema
203X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) fracture Multiple myeloma
(c) myeloma | | | INTERVAL BETWEEN ONSET AND DEATH
1 DAY
10 MONTHS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from DEC 18, 1966 to OCT 2, 1966 , that (I) was last saw the deceased alive on OCT 2, 1966 , and that death occurred at 8:55 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Samuel Sugar</i> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED
OCT 3 '66 |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Samuel Sugar | | 22d. ADDRESS
4637 Eastern Avenue, Washington, D.C. | |

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
District Heights | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | d. STREET ADDRESS
7408 Glendora Drive | |
| 3. NAME OF DECEASED (Type or print)
First
James
Middle
A.
Last
Taylor | | 4. DATE OF DEATH
Month
October
Day
2
Year
19 66 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 6, 1917 |
| 9. AGE (In years last birthday)
49 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY
GPO | |
| 11. BIRTHPLACE (County & State, or foreign country)
Tenn. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
David Taylor | | 14. MOTHER'S MAIDEN NAME
Margaret Wells | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Mary Lee Taylor | | Address
7408 Glendora Drive | |

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14650

CERTIFICATE OF DEATH

14652

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Since 1970, the number of people in the United States who are 65 years of age or older has increased from 15 million to 25 million. This increase is expected to continue, with the number of people aged 65 and over projected to reach 35 million by the year 2000. The increase in the number of people aged 65 and over is due to a combination of factors, including a decline in the birth rate, a decline in the death rate, and a decline in the rate of immigration.

References

VED.

10-6478

10/1/80

Approved: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14651

14653

| | | | |
|---|------------------------|--|-----------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt | | c. LENGTH OF STAY IN 1b 30 yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 44-C Crescent Road | | d. STREET ADDRESS 44 C Crescent Rd. | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle P. Last Tchikoff | | 4. DATE OF DEATH Month October Day 29 Year 19 66 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/27/1885 |
| 9. AGE (In years last birthday) 86 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 11b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (County & State, or foreign country) Ukrania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unk nown | | 14. MOTHER'S MAIDEN NAME ? Roussin | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Alla T. Ford - 114 S. Palm Way Lake Worth, Fla. | | 18. ADDRESS | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 Myocardial hemorrhage
DUE TO (b) Coronary sclerosis
DUE TO (c) General arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 10 years 15 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac prosthesis for past 3 months | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1946, to Oct. 29, 1966, that (I) (we) lost the deceased alive on Oct. 28, 1966, and that death occurred at 10 A M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Hans Wodak | | 22b. DATE SIGNED 10-31-1966 | |
| 22c. PHYSICIAN'S NAME (Type) Hans Wodak, M. D. | | 22d. ADDRESS Professional Bldg., Centerway, Greenbelt Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE THEREOF 11/3/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem. | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md. | |
| 24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. | | 25a. REC'D BY REGISTRAR NOV 7 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

14653

RECEIVED 14653

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14653

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14652

14654

| | | | | | | | |
|---|----------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | c. LENGTH OF STAY IN 1b
20 min. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lanham | | | 16.1 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | | | d. STREET ADDRESS
7904 Glenarden Parkway | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Baby Middle Girl Last Thomas | | 4. DATE OF DEATH
Month October Day 3 Year 1966 | | | | | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
October 3, 1966 | 9. AGE (In years lost birthday)
Yrs. | IF UNDER 1 YEAR
Months 0 Days 0 | IF UNDER 24 HRS.
Hours 0 Min. 20 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
-- | | 11. BIRTHPLACE (County & State, or foreign country)
Prince George's, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Joe Thomas | | | 14. MOTHER'S MAIDEN NAME
Willie Mae Howard | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT
Mother | | Address
as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hydrops Fetalis
7700 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) DUE TO
(c) DUE TO | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from October 3, 1966 , to October 3, 1966 , that (X) (we) last saw the deceased alive on October 3, 1966 , and that death occurred at 8:05AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Hugh G. Clark | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
Oct 3 1966 | |
| 22c. PHYSICIAN'S NAME (Type)
Hugh G. Clark, M.D. | | | | 22d. ADDRESS
4325 49th St. N.W. Wash., D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE THEREOF
10/8/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Prince George's Gen Hosp | | 23d. LOCATION (City or Town) (County) (State)
Cheverly PG Maryland | |
| 24. FUNERAL DIRECTOR
Narry W. Penn, Jr., Administrator, Cheverly, Md. | | | | 25a. REC'D BY REGISTRAR
OCT 13 1966 | | 25b. REGISTRAR'S SIGNATURE
f Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14653

CERTIFICATE OF DEATH

14655

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY PRINCE GEORGE'S
Leland Memorial Hospital MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MD. b. COUNTY PRINCE GEORGE'S
3115 Varnum St. Mt. Rainier, Md. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RIVERDALE | | c. LENGTH OF STAY IN lb
16.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Leland Memorial Hospital | | d. STREET ADDRESS 3115 Varnum St
3408 Queensbury Rd Hyattsville | |
| 3. NAME OF DECEASED
(Type or print) James Frank Thompson | | 4. DATE OF DEATH
Month Oct. Day 10 Year 19 66 | |
| 5. SEX
Male | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 11, 1889 |
| 9. AGE (In years last birthday)
77 yrs. | | 10. IF UNDER 1 YEAR
Months 77 Days 77 Hours 77 Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 11b. KIND OF BUSINESS OR INDUSTRY
Carpenter | |
| 11. BIRTHPLACE (County & State, or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Daniel Webster Thompson | | 14. MOTHER'S MAIDEN NAME
Unk. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
J.F. Thompson Jr. 2443 Monroe St. NW | |
| 17. INFORMANT
J.F. Thompson Jr. | | Address
2443 Monroe St. NW | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary atherosclerosis
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) coronary atherosclerosis DUE TO
(c) 2 years | | INTERVAL BETWEEN ONSET AND DEATH
2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1467 , 19 66 , to Oct 10 , 19 66 that (I) (we) last saw the deceased alive on Oct 6 , 19 66 , and that death occurred at 10 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
John L. H. H. | | 22b. DATE SIGNED
Oct 13 1966 | |
| 22c. PHYSICIAN'S NAME (Type)
Lee Funeral Home | | 22d. ADDRESS
300 4th St. N.E. Wash. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10-13-66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cem. | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor Md. | |
| 24. FUNERAL DIRECTOR
Lee Funeral Home | | 25a. REC'D BY REGISTRAR
Oct 13 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Judge | | | |

14653

CONFIDENTIAL OF DEATH

14653

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

[Faint, illegible text in the right margin, possibly a reference or classification code.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14654

14656

| | | | | | |
|---|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges.</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Pr. Geo.</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cheserly, Md.</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Carrollton.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Prince Georges General</u> | | | d. STREET ADDRESS
<u>6433 Fairbanks St</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
First <u>Emily</u> Middle <u>Todd</u> Last <u>Todd</u> | | | 4. DATE OF DEATH
Month <u>Oct.</u> Day <u>11</u> Year <u>1966</u> | | |
| 5. SEX
<u>FEMALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>June 22 1888</u> | | 9. AGE (In years last birthday)
<u>78</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | | 11. BIRTHPLACE (State or foreign country)
<u>ASHBURNHAM, MASS.</u> | |
| 13. FATHER'S NAME
<u>WILLIAM DELANEY</u> | | | 14. MOTHER'S MAIDEN NAME
<u>BRIDGET A. CARNEY</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service)
<u>028-22-5219</u> | | 17. INFORMANT
Address <u>George W. Todd 3516 Bradley Lane, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u>
DUE TO (c) <u>several years</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 hrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 12, 1962</u> to <u>Oct 11, 1966</u> , that (I) was last saw the deceased alive on <u>Sept 28, 1966</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<u>W H Clements</u> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>Sept Oct. 11, 1966</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>WILLIAM H. CLEMENTS</u> | | 22d. ADDRESS
<u>6001-35th Ave, Hyattsville Md 20782</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Oct 14 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St Bernards Cemetery</u> | |
| 23d. LOCATION (City, town, or county) | | 23e. (State) | | 23f. (Country) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>H. Don DeVol</u> | | ADDRESS <u>2222 Wisc, Am N. W.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>OCT 17 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

14655

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14657

| | | | |
|---|-----------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>PRINCE GEORGES COUNTY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | | c. LENGTH OF STAY IN 1b <u>8 mo 4 da</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | | d. STREET ADDRESS <u>4012 Van Buren Street</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4012 VAN BUREN ST Hyattsville</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>MICHAEL</u> Last <u>TROZZO</u> | | 4. DATE OF DEATH Month <u>OCT</u> Day <u>20</u> Year <u>1966</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>CAU</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 6, 1926</u> |
| 9. AGE (In years last birthday) <u>40</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>General Practice</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Ridgely, Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>FRANK MICHAEL TROZZO</u> | | 14. MOTHER'S MAIDEN NAME <u>Ella Kaiser</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW II</u> | | 16. SOCIAL SECURITY NO. <u>175-28-6667</u> | |
| 17. INFORMANT <u>Eleanor M. Trozzo</u> | | Address <u>4012 Van Buren Street Hyattsville, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u>
<u>2891</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Amyloidosis, primary</u>
DUE TO (c) <u>9 months</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HEPATIC FAILURE</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JAN 30 1966</u> , to <u>OCT 20 1966</u> , that (I) (we) last saw the deceased alive on <u>OCT 20 1966</u> , and that death occurred at <u>10¹⁵ AM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Paul A. DeVore</u> | | 22b. DATE SIGNED <u>10-20-66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>PAUL A. DEVORE, MD</u> | | 22d. ADDRESS <u>3415 HAMILTON ST Hyattsville, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Oct. 24, 1966</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u> | | 23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Clark E. Warner</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| Address <u>8334 Georgia Ave. Silver Spring, Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>OCT 25 1966</u> | | | |

1903

CERTIFICATE OF DEATH

1903

THIS CERTIFICATE OF DEATH is to be filled out by the physician or other person who has attended the deceased, or by the coroner, or by the registrar, or by the undertaker, or by the person who has taken charge of the funeral, or by the person who has taken charge of the burial, or by the person who has taken charge of the interment, or by the person who has taken charge of the cremation, or by the person who has taken charge of the other disposition of the body.

Full Name of Deceased: _____
Age: _____
Sex: _____
Date of Birth: _____
Date of Death: _____
Place of Death: _____
Cause of Death: _____
Signature of Physician: _____
Signature of Coroner: _____
Signature of Registrar: _____
Signature of Undertaker: _____
Signature of Person in Charge of Funeral: _____
Signature of Person in Charge of Burial: _____
Signature of Person in Charge of Interment: _____
Signature of Person in Charge of Cremation: _____
Signature of Person in Charge of Other Disposition: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14656

CERTIFICATE OF DEATH

14658

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY PRINCE GEORGES MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY PRINCE GEORGES | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORESTVILLE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORESTVILLE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
REGENCY NURSING HOME, MARLBORO PIKE | | d. STREET ADDRESS
5437 SPRING STREET | |
| 3. NAME OF DECEASED (Type or print)
First CARLO Middle VOLTA Last
4. DATE OF DEATH OCTOBER 31, 19 66 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 20, 1884 |
| 9. AGE (In years last birthday)
82 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY
GROCEER | |
| 11. BIRTHPLACE (County & State, or foreign country)
ITALY | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
UNKNOWN | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
ARMAND J. VOLTA | | Address
3300 Roslyn Ave. District Hgt. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerotic Cardiovascular Disease
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug , 19 64 , to Oct , 19 66 that (I) (we) last saw the deceased alive on 10-31 , 19 66 , and that death occurred at 11 P M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
John F. Shay | | 22b. DATE SIGNED
11-1-66 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS
5509 Fiber Hill Rd, Suitland, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
NOV. 3, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
PRINCE GEORGES, MARYLAND | |
| 24. FUNERAL DIRECTOR
ROBERT E WILHELM | | ADDRESS
FUNERAL HOME 4308 SUITLAND ROAD | |
| 25a. REC'D BY REGISTRAR
NOV 4 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

14625

REMARKS OF DEATH

14625

Form with multiple lines for text entry, including fields for name, date, and other details. The text is faint and mostly illegible.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

14657

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14659

| | | | |
|--|------------------------|--|--------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 2 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | d. STREET ADDRESS 7611 Topton Street | |
| 3. NAME OF DECEASED (Type or print) First Robert Middle H Last Wagenhouser | | 4. DATE OF DEATH Month October Day 5 Year 1966 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/3/90 |
| 9. AGE (In years last birthday) 76 yrs. | | 10. IF UNDER 1 YEAR Months Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Auto Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY Self | |
| 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S. A | |
| 13. FATHER'S NAME James Wagenhouser | | 14. MOTHER'S MAIDEN NAME Jennie Hosler | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 212-20-1578 | |
| 17. INFORMANT Margaret E. Wagenhouser | | Address Same as #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 2043 DUE TO Acute myocardial infarction
(b) Anteroseptal heart infarction
(c) Acute leukemia, type undetermined
Acute hemorrhagic pulmonary edema.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb, 1966 to Oct 6, 1966 that (I) (we) last saw the deceased alive on Oct 3, 1966, and that death occurred at 2:30 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE William D. Rosson M.D. | | 22b. DATE SIGNED Oct 7, 1966 | |
| 22c. PHYSICIAN'S NAME (Type) William D. Rosson, M.D. | | 22d. ADDRESS 5701 85th Ave. Hyattsville, Md. | |
| 23a. BURIAL, CREMATION, or other disposal (Specify) Burial | | 23b. DATE THEREOF 10/8/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Holy Trinity | | 23d. LOCATION (City or Town) Collington (County) P.G. (State) Md. | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DATE OCT 10 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14658

14660

| | | | | | | | |
|---|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George's</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cheverly</u> | | c. LENGTH OF STAY IN 1D
<u>1 month</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hanover</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Prince George General Hospital</u> | | | | d. STREET ADDRESS
<u>7411 Hawkins Drive, Rt. 1</u> | | | |
| 3. NAME OF DECEASED
(Type or print)
<u>Elna</u> | | First Middle Last
<u>Ward</u> | | 4. DATE OF DEATH
Month <u>10</u> Day <u>11</u> Year <u>19 66</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>2-23-1908</u> | | 9. AGE (In years last birthday)
<u>58</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Pasadena, Mi.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Harry D. Cook</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Sarah Chard</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
<u>Earl Cook, Crownsville, Mi.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia with congestive heart failure</u>
8164 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture of spleen</u>
DUE TO (c) <u>Trauma auto accident</u>
INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Carcinoma of left breast with axillary metastases</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Passenger of car involved in collision</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>8:45pm</u> <u>9-11-</u> <u>19 66</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Rt. 301 at Queen Ann Rd., Upper Marlboro, Md.</u> | | 20f. (City or town) (County) (State)
<u>Upper Marlboro, Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
<u>John Kehoe</u> | | M.D. <u>John Kehoe, M.D. Riverdale, Md.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED
<u>10-11-66</u> | |
| EXAMINER'S NAME (Type)
<u>John Kehoe, M.D. Riverdale, Md.</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Address (Street, city, town, or county)
<u>Lake Shore, Pasadena, Mi.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>14 October</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Carmel Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Lake Shore, Pasadena, Mi.</u> | |
| 24. FUNERAL DIRECTOR
<u>Kirkley Funeral Home, Glen Burnie, Md.</u> | | | | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
<u>OCT 14 1966</u> <u>Charles Judge</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14622

MEDICAL EXAMINING CERTIFICATE OF DEATH

14622

FOR THE USE OF THE

Blank form with faint lines and text, including a large circular hole on the right side.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G381 10/13/66 mh

14659

CERTIFICATE OF DEATH

14661

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH Prince George's
a. COUNTY <u>Forestville</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geor.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>the Regent</u> | | d. STREET ADDRESS
<u>1450 Marlboro Pike Suitland, Md.</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Roberta</u> Middle <u>Mae</u> Last <u>Ward</u> | | 4. DATE OF DEATH
Month <u>10</u> Day <u>7</u> Year <u>19 66</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>10/9/1879</u> |
| 9. AGE (In years last birthday)
<u>86 1/2</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Christopher William</u> | | 14. MOTHER'S MAIDEN NAME
<u>Annie Carriso</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Joseph Knott #18 Ky. Ave. Parkland, Md.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary thrombosis</u>
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Arteriosclerotic Heart disease</u>
DUE TO
(c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>immediate</u>
<u>many years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10 6</u> , 19 <u>66</u> , to <u>10-7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-6</u> 19 <u>66</u> , and that death occurred at <u>8:15</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>W.B. Sheer</u> | | 22b. DATE SIGNED
<u>10-7-66</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>WALTER B. SHEER</u> | | 22d. ADDRESS
<u>6400 Marlboro Pike S.E. WASH. District Heights, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>10/10/66</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Prince Georges Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Wilhelm Funeral Home</u> ADDRESS
<u>4308 Suitland Rd. Suitland Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>OCT 11 1966</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. ...</u> | |

14624

THE RECORD OF DEATH

14624

RECEIVED
JAN 10 1900
U.S. DEPT. OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| Item 8 Film G582 11/7/66 mh | | | | | | | | | |
| 14660 CERTIFICATE OF DEATH 14663 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Pro George's | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville, Md. | | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville Md. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
4305 Farragut st | | | | | d. STREET ADDRESS
4305 Farragut St | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Bertha Middle B Last Weber | | | | | 4. DATE OF DEATH
Month Oct Day 26 Year 19 66 | | | | |
| 5. SEX
female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1886 May 22, 1876/ | | 9. AGE (In years last birthday) yrs. 80 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
own home | | 11. BIRTHPLACE (County & State, or foreign country)
Washington D. C. | | | 12. CITIZEN OF WHAT COUNTRY?
U-S-A. | | |
| 13. FATHER'S NAME
Fritz Walker | | | | | 14. MOTHER'S MAIDEN NAME
Bertha Shellhorn | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Dolphin W Weber Address Hyattsville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Influenza | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 hours
10 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan , 19 56 to Oct , 19 66 that (I) (we) last saw the deceased alive on Oct 25 , 19 66 and that death occurred at 7:30 PM from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Leon R. Gallin M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
10/27/66 | | |
| 22c. PHYSICIAN'S NAME (Type)
Leon L. Gallin M.D. | | | | | 22d. ADDRESS
7206 Adelphi Rd. W. Hyattsville, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Oct 29, 1966 | | 23c. NAME OF CEMETERY OR CREMATOR
Ft Lincoln Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor Pro Geo Md. | | |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons ADDRESS Hyattsville, Md. | | | | | 25a. REC'D BY REGISTRAR
DATE OCT 31 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

14663

ENDING AND OF DEATH

14663

388

380

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14661

CERTIFICATE OF DEATH

14664

| | | | | | | | |
|--|----------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Mont. Co ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | c. LENGTH OF STAY IN 1b
5 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Kensington | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince Georges General Hospital | | | | d. STREET ADDRESS
11301 Mitscher St. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Alice Middle J Last Wessel | | | | 4. DATE OF DEATH
Month Oct. Day 29 Year 1966 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
23 June 1888 | | 9. AGE (In years last birthday)
78 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
D.C. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Peter C. McCloskey | | | | 14. MOTHER'S MAIDEN NAME
MARY J. Whalen | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
John J. Wessel <i>Rem. Address 11301 MITSCHER ST.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory failure
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) cerebral Thrombosis DUE TO
(c) Asevd | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 days
years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/25 , 19 66 , to 10/29 , 19 66 , that (I) (we) last saw the deceased alive on 10/29 19 66 , and that death occurred at 3:30 PM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Paul A DeVore</i> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
10-30-66 | |
| 22c. PHYSICIAN'S NAME (Type)
PAUL A DeVORE, MD | | | | 22d. ADDRESS
3415 HAMILTON ST Hyattsville, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
11-3-66. | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY
State of Heaven | | 23d. LOCATION (City or Town) (County) (State)
Wheaton Md. | |
| 24. FUNERAL DIRECTOR
Hanlon Funeral Home | | | | ADDRESS
Wash. D.C. | | 25a. REC'D BY REGISTRAR
NOV 3 1966 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

14004

LIBRARY OF CONGRESS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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107

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14662

CERTIFICATE OF DEATH

14665

| | | | |
|--|---------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE D. C. b. COUNTY --- | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hvattsville | | c. LENGTH OF STAY IN 1b
4 Months | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington 47-3 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Hvattsville Nursing Home | | d. STREET ADDRESS
819 East Capitol St. | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First May Middle Last Whittaker | | 4. DATE OF DEATH
Month Oct. 24 Day 19 66 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
Dec. 7, 1878 |
| 9. AGE (In years last birthday) yrs.
87 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| 11. BIRTHPLACE (County & State, or foreign country)
Vermont | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Isaac C. Whittaker | | 14. MOTHER'S MAIDEN NAME
Fannie Kirbv | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Terminal bronchopneumonia</u>
332X
DUE TO
(b) <u>CVA (Thrombosis) Left Hemiplegia</u>
DUE TO
(c) <u>Advanced severe arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH
3 days
1 month
2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Seizures and senile dementia</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from May 25, 1966, to Oct 24, 1966, that (1) (we) last saw the deceased alive on 10-22 19 66, and that death occurred at 4 a. M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Herbert S. Gates | | 22b. DATE SIGNED
10-24-66 | |
| 22c. PHYSICIAN'S NAME (Type)
HERBERT S. GATES | | 22d. ADDRESS
819-EAST CAPITOL ST. D.C. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/27/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Suitland Maryland | |
| 24. FUNERAL DIRECTOR
J. Wm. Lees Sons | | 25a. REC'D BY REGISTRAR
Washington, D. C. DATE OCT 26 1966 | |
| 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

14683

OFFICE OF LEAD

14683

Special Division

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|---|
| 14663 | | | | | 14666 | | | | |
| 1. PLACE OF DEATH
a. COUNTY | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE | | | | |
| Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cheverly | | | | | Maryland
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Riverdale | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Prince George's General Hospital | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Charles N. Winters | | | | | 4. DATE OF DEATH
Month Day Year
October 8, 1966 | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2/19/83 | | 9. AGE (In years last birthday)
83 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY
Real Estate | | 11. BIRTHPLACE (County & State, or foreign country)
New Jersey | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 13. FATHER'S NAME
Charles N. Winters | | | | | 14. MOTHER'S MAIDEN NAME
Emma Robinson | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
(If yes give war or dates of service) No | | 17. INFORMANT
Florence M. Winters | | Address
Same as # 2 (Wife) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Adenocarcinoma of rectum</u>
154X DUE TO (b) <u>Cardiovascular Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Insider 10-4-66</u> | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-1-1966</u> to <u>10-8-1966</u> , that (I) (we) last saw the deceased alive on <u>10-8-1966</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>George J. Hageage</u> | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>10-8-66</u> | | |
| 22c. PHYSICIAN'S NAME (Type)
George J. Hageage | | | | | 22d. ADDRESS
3717 38th Ave., Cottage City, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/10/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION (City, town or county) (State)
Colmar Manor Maryland | | | |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons Hyattsville, Maryland | | | | | 25a. REC'D BY REGISTRAR
DATE OCT 11 1966 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

14668

14668

Prince George's

Harvey

Prince George's

Cherish

29 days

Riverdale

6128 Kentworth Avenue

Prince George's General Hospital

October

Vincent

M.

Cherish

83

2/19/83

White

Male

New Jersey

Red

Richard Williams

same address

Charles J. Williams

Prince George's General Hospital

2/19/83

No

No

3717 38th Ave., Cottage City, Md.

George J. Williams

Colman Avenue, Maryland

St. Lincoln Cemetery

10/1/83

Boyd

St. George's General Hospital, Maryland

Two

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14664

CERTIFICATE OF DEATH

14667

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY IN lb
10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince George's General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Riverdale
d. STREET ADDRESS
6107 62nd Place
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Charles Harry Wolfe | | 4. DATE OF DEATH
Month Day Year
October 19 19 66 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 9, 1900 |
| 9. AGE (In years lost birthday)
66 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Engineer Aid | | 10b. KIND OF BUSINESS OR INDUSTRY
Wash. Sub. San. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Harry Wolfe | | 14. MOTHER'S MAIDEN NAME
Marguerite Massey | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
218 20 1550A | |
| 17. INFORMANT
Catherine G Wolfe | | Address
E Riverdale, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrhythmia
4201 OUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) thrombosis of coronary arteries
OUE TO (c) arteriosclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
pulmonary emphysema, embolism | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 9, 1966 to Oct 19, 1966 that (I) (we) last saw the deceased alive on Oct 19, 1966 and that death occurred at 2:15 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Don B. Cameron | | 22b. DATE SIGNED
Oct 20, 1966 | |
| 22c. PHYSICIAN'S NAME (Type)
DON B. CAMERON | | 22d. ADDRESS
3503 PERRY ST. RAINIER | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Oct 22, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor Pro Geo Md. | |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons | | 25a. REC'D BY REGISTRAR
OCT 24 1966 | |
| ADDRESS
Hyattsville, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

10241

32287

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14665 CERTIFICATE OF DEATH 14668

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | |
| c. LENGTH OF STAY IN 1b <u>2 yr</u> | | d. STREET ADDRESS <u>7403 Buchanan St.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Paint Branch Nursing Home</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Mrs. Catherine Eulalia Wood</u> | | 4. DATE OF DEATH Month <u>10</u> Day <u>2</u> Year <u>1966</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 16 1881</u> |
| 9. AGE (In years last birthday) <u>84</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Wash D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John O'Neill</u> | | 14. MOTHER'S MAIDEN NAME <u>Georgina Whitney</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>— —</u> | |
| 17. INFORMANT <u>Nursing Home Records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>
1914 DUE TO <u>Metastatic Carcinoma to neck glands</u>
DUE TO <u>Carcinoma of skin of neck</u>
underlying cause last. (c) <u>2 mo.</u>
<u>2 yrs.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 11, 1963</u> , to <u>Sept 28, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 28, 1966</u> , and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>R.D. Baxter M.D.</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>R.D. Baxter, M.D.</u> | | 22d. ADDRESS <u>2513 Buck Lodge Rd. Adelphi, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Oct 5, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | 23d. LOCATION (City, town or county) (State) <u>Suitland Pro Geo Md.</u> |
| 24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> | | 25a. REC'D BY REGISTRAR <u>OCT 5 1966</u> | |
| ADDRESS <u>Hyattsville, Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

MEDICAL CERTIFICATION

1966

1966

END PAGE

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

14666

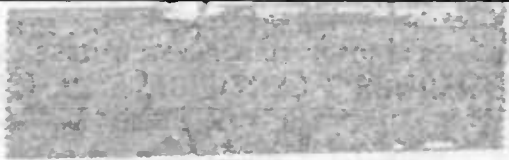
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14670

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George's</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>
c. LENGTH OF STAY IN 1b <u>DOA</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chamber's Funeral Home</u> | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>Prince George's</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>
d. STREET ADDRESS <u>2200 Phelps Rd., Apt. H1</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>John Joseph Zemerlin</u>
4. DATE OF DEATH <u>10 10 19 66</u> | | 5. SEX <u>Male</u>
6. COLOR OR RACE <u>White</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <u>26 June 1912</u>
9. AGE (In years last birthday) <u>54</u> yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRouble SHOOTER</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>FAIR LANE CORP</u>
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>JOHN ZEMERLIN</u>
14. MOTHER'S MAIDEN NAME <u>FRANCES LESKO</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>
17. INFORMANT <u>MRS FRANCES PASCIA</u> Address <u>ADAM PENNA.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Heart failure</u>
4200 DUE TO <u>Arteriosclerotic heart disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | INTERVAL BETWEEN ONSET AND DEATH
<u>minutes</u>
<u>unknown</u> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.
EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u> Address (Street, city, town, or county) <u>Riverdale, Md.</u> | | 22. DATE SIGNED <u>10-11-66</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>
23b. DATE THEREOF <u>OCT 14, 1966</u>
23c. NAME OF CEMETERY OR CREMATORY <u>MASONTOWN, PENN.</u>
23d. LOCATION (City, town or county) (State) | |
| 24. FUNERAL DIRECTOR <u>W.W. Chambers Co. Riverdale, Md.</u> ADDRESS | | 25a. REC'D BY REGISTRAR <u>OCT 14 1966</u>
25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u> | |

14000

14000



[Faint, mostly illegible text covering the majority of the page, appearing to be a document or report.]